OLUME 14 • JANUARY 1959 • NUMBER 1

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

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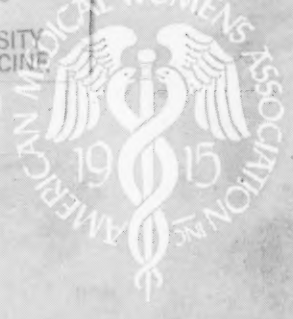

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*Schneeberg, N. G.; Perczek, L.; Nodine, J. H., and Perloff, W. H.: Methallenestril, a New Synthetic Estrogen, J.A.M.A. *161*:1062 (July 14) 1956.

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1. Current personal communications; in the files of Wallace Laboratories. 2. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride, J.A.M.A. 166:1019, March 1, 1958.

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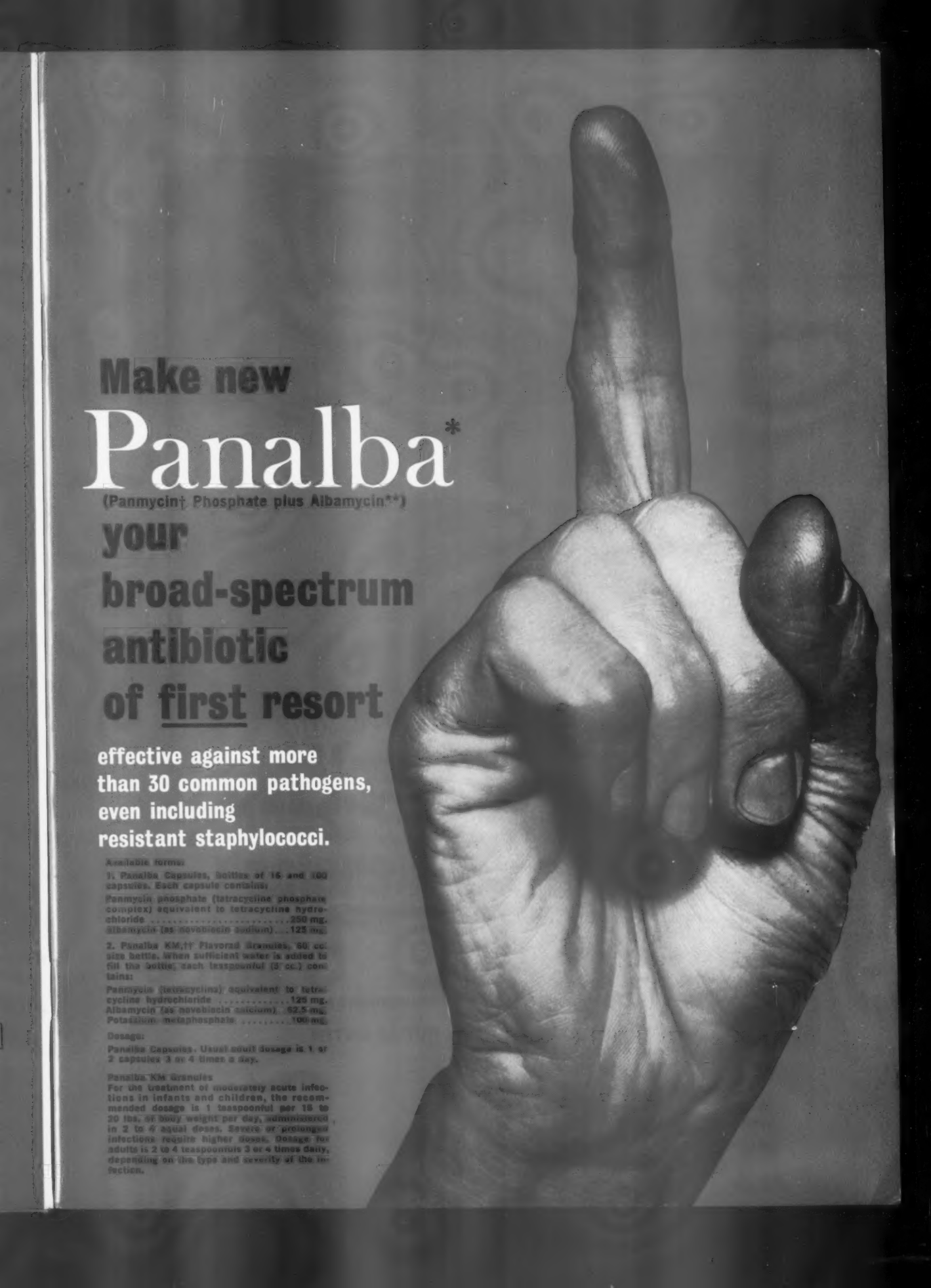
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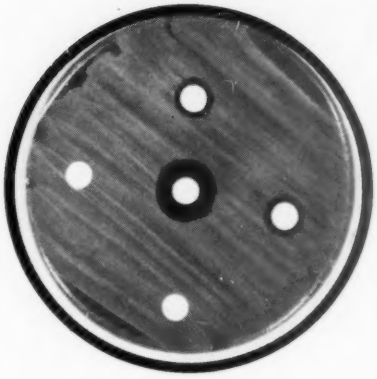
on the problem of antibiotic-resistant bacteria



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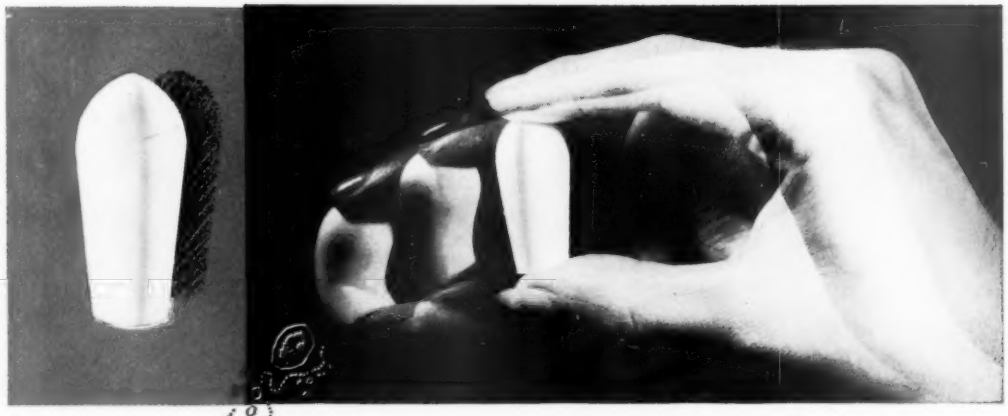

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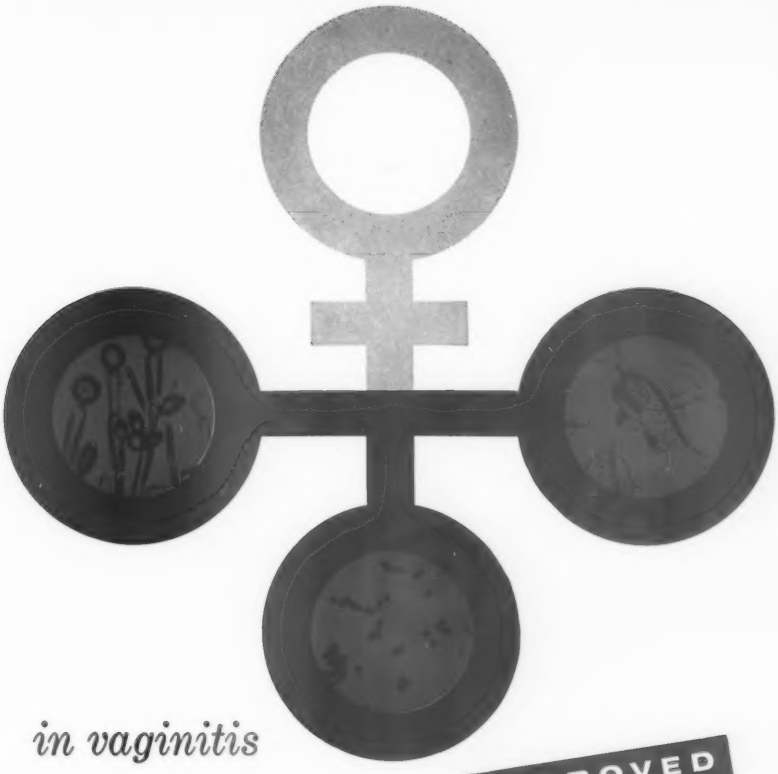

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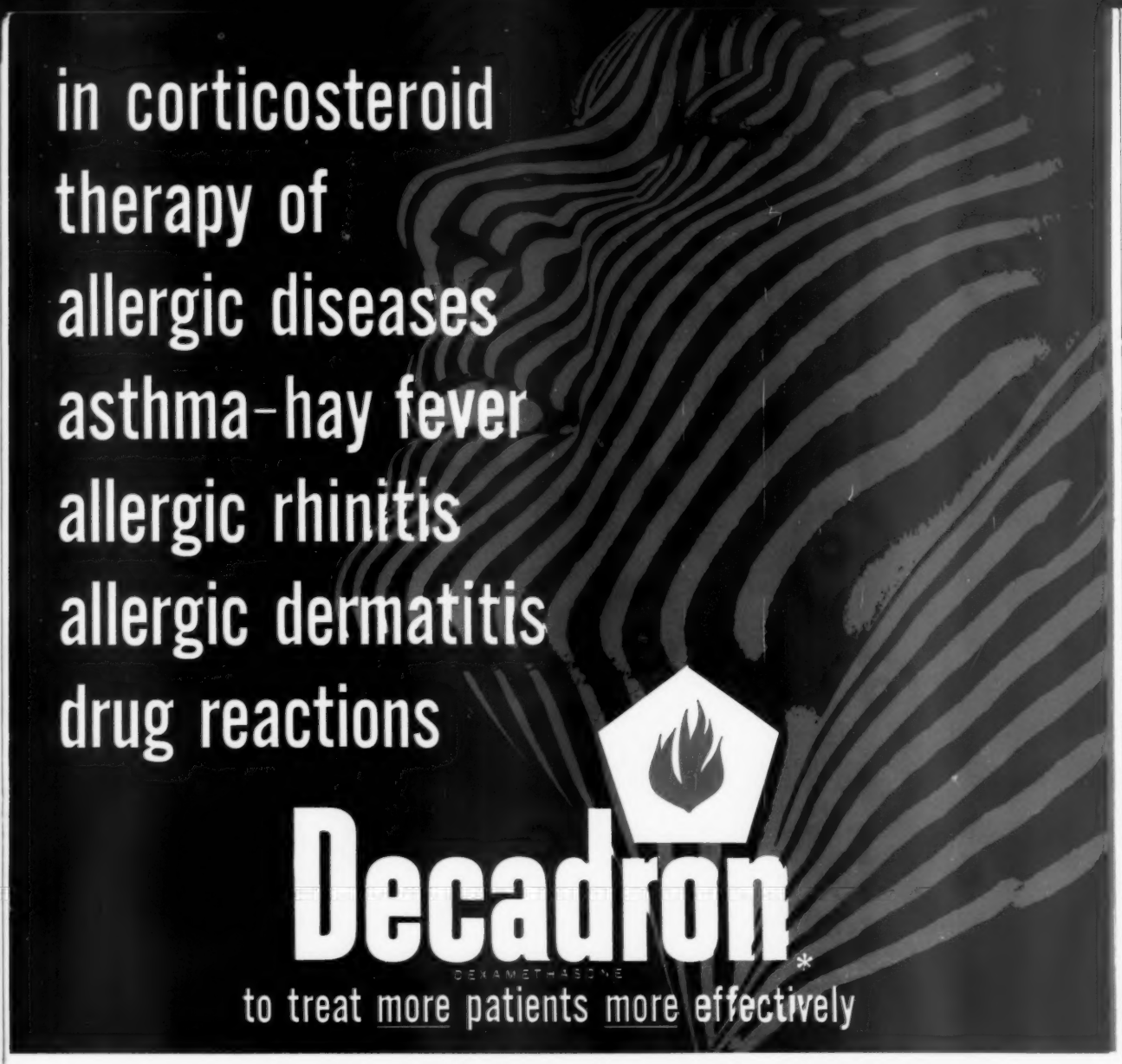

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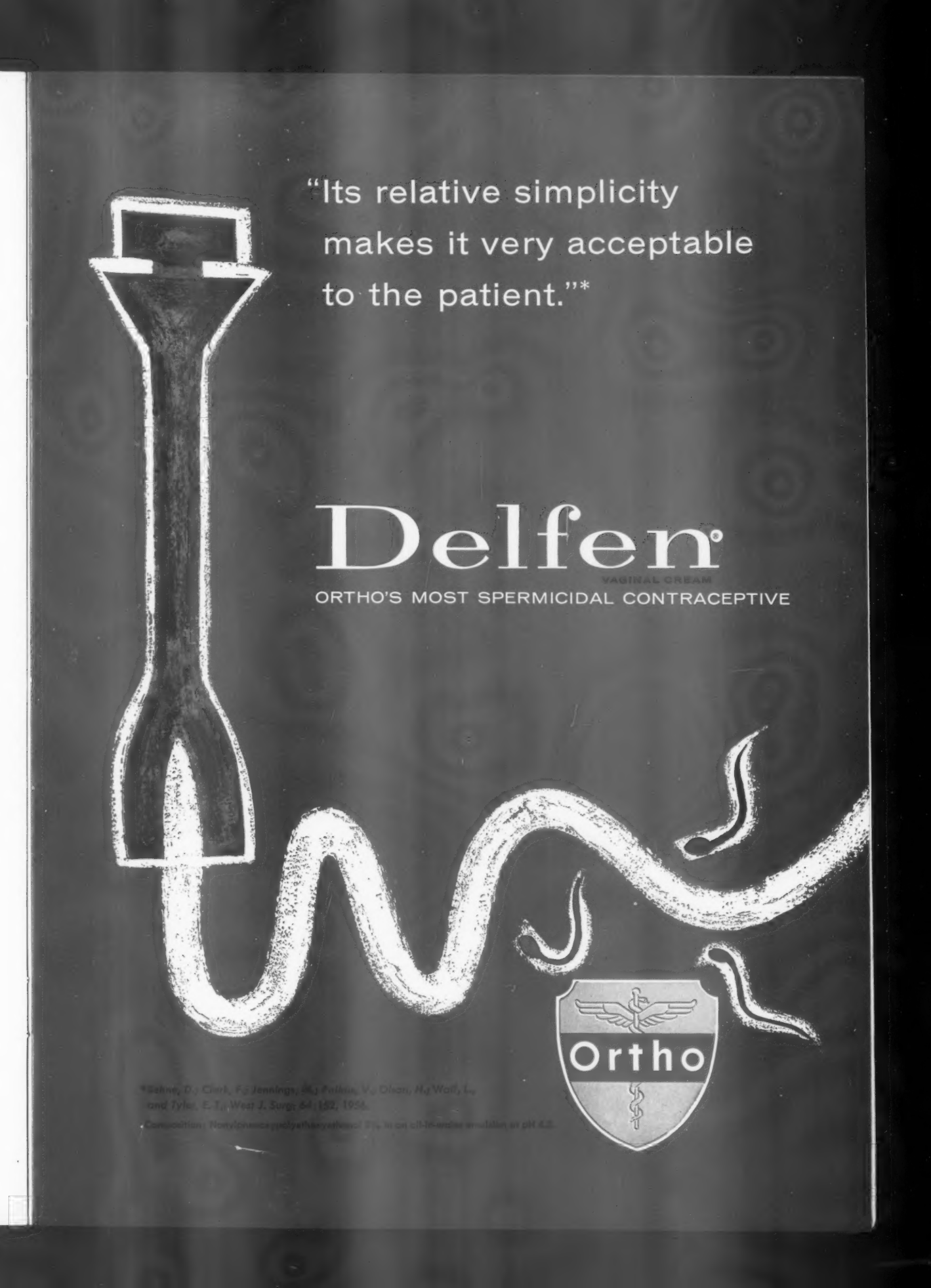
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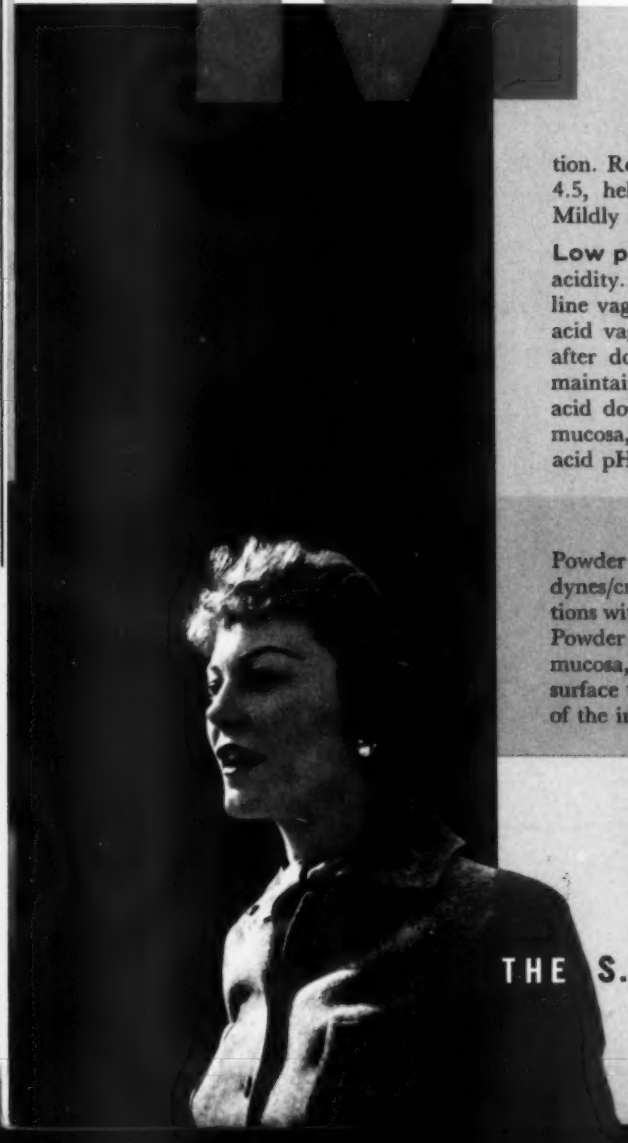

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1. Lang, W.R., Rakoff, A.E., Am. Geriatrics Soc. 7:520 (1953)
2. Arnot, P.H., The Problem of Douching, Western Journal of Surg., Obs., and Gyn., Vol. 62, No. 2:85 (1954)

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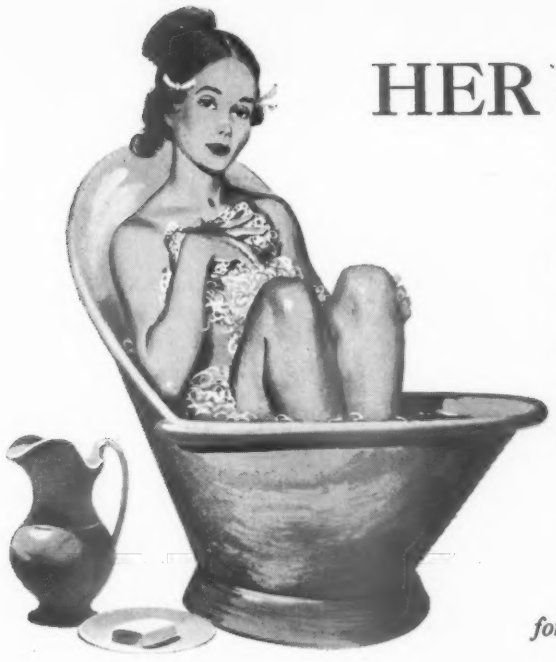

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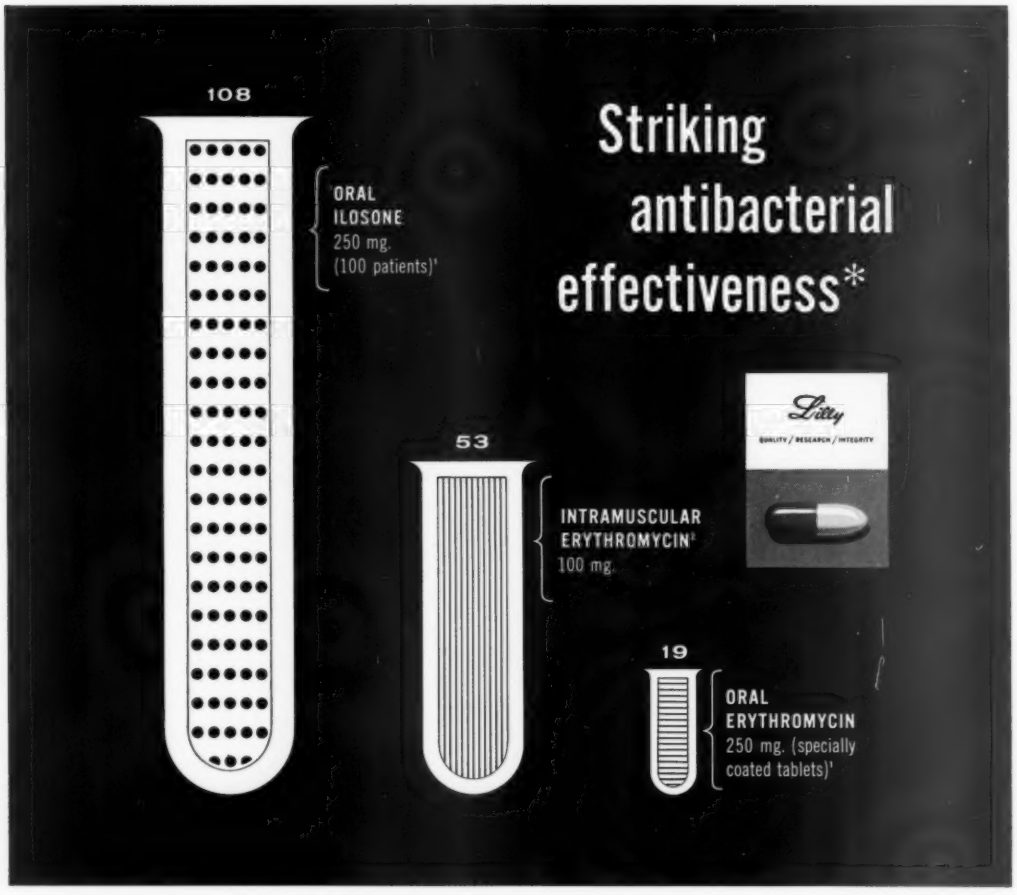

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1. Griffith, R. S., *et al.*: Antibiotic Med. & Clin. Therapy, *5*:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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Volume 14 JANUARY, 1959 Number 1

Nutritional Pitfalls of Prosperity*

GRACE A. GOLDSMITH, M.D.

NUTRITIONAL PROBLEMS occur in times of prosperity as well as in those of economic depression. In these contrasting situations the problems differ in kind, frequency, and distribution among various segments of the population. This discussion will consider some of the important nutritional problems encountered at the present time in a prosperous country such as the United States. Consideration will be limited to the problems of the young and middle-aged adult in that somewhat indefinite period of years that has been referred to as "the prime of life."

Since this discussion forms part of a one hundredth anniversary celebration, it seems pertinent to ask whether the nutritional problems of a prosperous adult population in the present century are the same as those observed 100 years ago. This question cannot be answered precisely since knowledge of nutrition was extremely meager in 1858. At that time, it had been shown that foods contained protein, carbohydrate, and fat rather than a single nutrient element, a view held by many in the early 1800's. Also, experiments in animals in the mid-nineteenth century suggested that minerals were vital dietary constituents. Vitamins were unknown as yet and the concept that disease could be caused by lack of some essential dietary factor had not been formulated.

One nutritional problem that is common today among the prosperous was encountered frequently in the past, not only 100 years ago but also many thousands of years ago, namely, obesity. Garrison [1] states that the first art of the Stone Age (Paleolithic period—as far back as 22,000 B.C.) depicted the female as obese: "This particular type, an index of the overfed life of a woman in prehistoric caves," was presented in sculpture and carvings for many centuries.

That excessive accumulation of body fat might be undesirable from a health standpoint was suggested only occasionally in medical literature prior to the twentieth century. For example, in 1863, William Banting in his "Letter on Corpulence" proposed the cure of obesity by the general reduction of food, including the exclusion of fats and carbohydrates from the diet.[1] However, in general, moderate adiposity was admired as an indication of health, beauty, and affluence. In the present century there has been increased interest in obesity: its potential health hazards, prevention, and treatment. Obesity is no longer fashionable. Recent investigations have been directed toward elucidating causative factors of obesity, ascertaining whether biochemical and metabolic abnormalities may be

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Dr. Goldsmith is Professor of Medicine, Tulane University School of Medicine, New Orleans.

found in obese persons, and developing methods for determining the degree of body fatness. This last was necessary since overweight in comparison to some standard for height, age, and sex is not synonymous with obesity. Overweight can result from heavy skeletal structure, large muscles, or accumulation of water, as well as from an overabundance of fat. Procedures used to determine body fatness or leanness include: (1) estimation of body density by weighing in water and air, (2) determination of total body water, and (3) measurement of the thickness of subcutaneous fat by means of roentgen-ray photographs or with specially constructed calipers.[2] The first two procedures are useful in research, the third in everyday medical and nutritional evaluation. Measurement of skin fold thickness appears to be most useful and studies thus far indicate good correlation with estimation of body density. Standards or norms for skin fold thickness which may be applied in studies of obesity are being developed[3] but, as yet, diagnosis of obesity is far from precise. The normal range for total body fat is unknown as is the degree of deviation disadvantageous to health.

In view of the afore-mentioned, the incidence of true obesity has not been determined. Information is available on the incidence of overweight, but even these data are dependent on inexact standards used for evaluating weight and the deviation from standards considered to be abnormal. It has been suggested that an adult may be considered overweight if his weight exceeds by 15 to 20 per cent the average weight for height at age 30, taking into consideration body build and muscular development. On this basis, perhaps one in five persons over 30 years of age in this country is overweight. A number of findings suggest that this degree of overweight may adversely affect health.

The incidence of overweight increases up to about the age of 40 in men and 50 years in women. Since more people are living longer, the total number of overweight persons is presumably increasing. Whether the percentage incidence of overweight is increasing is not known since accurate figures for representative samples of the population of 50 to 100 years ago are not available for comparison with current data. Hundley[4] has cited evidence that indicates that men are somewhat heavier and women somewhat lighter than they were 30 or 40 years ago. Bennett[5] has pointed out that the per capita consumption of calories has declined about 5 per cent in the past 35 years. At least part of this decline may be due to a decrease in the amount of food ingested rather than to a change in the amount of food waste. Even if total caloric consumption is lower than in former years, the incidence of overweight may be increasing due to a decrease in physical activity and in energy needs. In this age of mechanization, the physical activity in occupational and recreational pursuits is certainly less than in former years.

Most of our information as to the health hazards of obesity is actually information relating mortality rates to overweight. Since 1901, when Rogers reported a heightened mortality among insured persons who were overweight, "a succession of medico-actuarial studies . . . has uniformly shown that overweight is associated with an increased mortality from several diseases, notably cardiovascular disorders and particularly in men."[6] Dublin and Marks[7] and Armstrong and associates[8] reported mortality experience with insurance policy holders who were limited to substandard insurance solely because of overweight. In comparison with standard risks, the overweight group over a period of 16 to 25 years had an excess death rate from all causes of some 50 per cent. Mortality rates tended to rise with the degree of overweight. The number of deaths from cardiovascular-renal diseases was approximately one and one-half times that expected on the basis of standard experience. A lower mortality rate was noted among men who reduced their weight and were subsequently granted insurance at lower rates of premium.

Recently, the relationship between overweight, obesity, and heart disease, at least atherosclerosis and ischemic heart disease, has been challenged,[9,10] and the validity of conclusions from insurance statistics has been questioned. In answer to this, Gubner[6] has evaluated mortality rates of comparable underweight and overweight groups in several insurance studies emphasizing that the underweight groups constitute a more proper control than the group of average weight. The latter may be excessively fat. He found that underweight persons fared better than overweight ones in all groups studied except younger women. The longer the follow-up study the greater was the disparity between the groups. In an Equitable Life study of in-

surance policy issues, a threefold increase in cardiovascular disease mortality was noted as body build progressed from 10 to 29 per cent underweight to 30 to 39 per cent overweight. Findings suggested that underweight was associated with less coronary artery disease. Recent epidemiologic studies in Framingham, Mass., Albany, N. Y., and Los Angeles indicate an increase in the risk of developing ischemic heart disease in the overweight.[11]

Several pathological studies have indicated significant differences in the degree of coronary atherosclerosis between overweight and underweight persons but not between those who were overweight and those of average weight.[6] It should be noted, however, that no correlation between terminal body weight and acute myocardial infarction was found by Thomas and associates.[12]

In spite of the controversial evidence, there appears to be some relationship between overweight (and presumably fatness) and coronary artery disease. There does not seem to be an association between obesity and atherosclerosis in other sites such as the aorta.[6] The association between overweight and coronary artery disease may be in relation to complications of atherosclerosis, such as thrombosis, rather than to the primary process.

The incidence of hypertension, renal disease, diabetes mellitus, gall bladder disease, cirrhosis of the liver, and degenerative arthritis has been reported to be increased in overweight persons.[8] Some studies have indicated that sustained hypertension is nearly three times as common in groups of overweight persons as in other groups. However, in a recent report from Norway,[13] no relationship between obesity and hypertension was observed. Most clinicians are agreed that a history of preceding obesity is found in about 80 per cent of persons who develop diabetes in adult life. The apparent association of overweight with a variety of pathological states militates against a simple direct relationship between the presence of excess fat and the initiation of these conditions. The same diseases occur in lean individuals, and obese persons may live to old age without developing these diseases. If obesity functions as a causative factor, the mechanism of action is obscure and complex. If the association of obesity with these diseases rests upon a common cause such as some type of reaction inherent in the germ plasm, then the value of weight reduction in the prevention and treatment of these diseases is problematical. There is a need for long-term studies of the effects of weight reduction on the incidence of various pathological states. It has been shown that loss of weight is often beneficial in obese persons with hypertension. In many middle-aged diabetics, reduction of weight is sufficient to control hyperglycemia and glycosuria. There is no doubt that excess weight increases the work of the heart and that loss of weight is important in the therapy of obese persons with cardiovascular disease. The benefits of weight reduction in the management of degenerative arthritis and in making the surgeon's job easier are well recognized. Marked obesity seriously handicaps the individual in his daily life and may lead to psychic and emotional problems, as well as stem from such disturbances.

The fundamental cause of obesity is a positive energy balance, that is, the energy supplied by the food consumed is greater than the energy expended for basal metabolic needs and physical activity. Thus, the principal factors responsible for the development of obesity are excessive food consumption or insufficient energy expenditure. In recent research, attention has been directed to biochemical, physiological, psychological, and sociological regulators of food consumption and of energy expenditure.

Studies in animals have shown that obesity may be induced by genetic factors, trauma to the hypothalamus, injection of gold thioglucose, grafting of ACTH-secreting pituitary tumors, forced feeding, thyroidectomy, and limitation of activity in association with a semiliquid diet but no water. Experimental obesity due to hypothalamic lesions or induced by gold thioglucose appears to be due to abnormality of the central nervous system mechanism that regulates food intake, while hereditary obesity is the result of an inborn abnormality of metabolism. Inactivity also plays a role in some types of experimental obesity. There are marked metabolic and behavioral differences between hereditary obesity and that induced by hypothalamic lesions or injections of gold thioglucose, and smaller differences between the latter two.[14] Mice with hereditary obesity have increased food intake (25 per cent above normal) with a preference for fat, low basal oxygen consumption per unit of body size, and greatly reduced physical activity. These mice are hyperglycemic and glycosuric, refractory to insulin, and sensitive to growth hormone. The blood

cholesterol level is high, and incorporation of administered acetate into fatty acids is considerably increased. This suggests a metabolic derangement resulting in increased lipogenesis. Mice made obese by injection of gold thioglucose increase their food intake 50 to 70 per cent above normal; have normal basal oxygen consumption, normal activity, and normal blood sugar levels; show no response to growth hormone; and are insulin-sensitive. The blood cholesterol level is only slightly elevated and incorporation of acetate into fatty acids is normal.

It is of considerable importance to know whether there are several types of obesity in man and whether hereditary metabolic abnormality or dysfunction of the central nervous system regulation of food intake may be a causative factor. Evidence for hereditary obesity is meager. There is certainly a familial tendency but it has not been shown that this is genetically based. It might result from familial food habits. It has been postulated that some persons have a metabolic pattern that results in increased lipogenesis but there are few substantiating data.

Pennington [15,16] hypothesized a defect in carbohydrate metabolism resulting in accumulation of pyruvate, which in turn depressed oxygenation of fat and increased lipogenesis from carbohydrate. The large proportion of carbohydrate and fat diverted to storage, instead of being utilized for energy, might result in an increase in appetite to supply bodily needs. Little evidence in support of this theory is available. Miller and Thomas [17] found that basal pyruvate levels were not elevated in obese persons and that pyruvate increased normally after glucose administration. The rise in blood pyruvate and lactate after exercise was greater in obese than in normal persons, possibly due to circulatory inadequacy. Kekwick and Pawan [18] noted greater weight loss on isocaloric diets when 90 per cent of the calories was derived from fat than when a similar percentage was obtained from protein or carbohydrate. They interpreted these findings as suggesting metabolic differences in obese as compared to nonobese persons. Werner [19] found no difference between high-fat low-carbohydrate and low-fat high-carbohydrate regimens for weight reduction. Hawthorne and associates [20] compared the calorie expenditure above basal after test meals high in fat and high in carbohydrate in underweight, "desirable" weight, and overweight subjects. Calorie expenditure was highest in the overweight and lowest in the underweight subjects with both test meals, differences being more marked with the meal high in fat. The underweight group produced slightly fewer calories after the high-carbohydrate meal than after the high-fat meal while the other groups produced somewhat more. A significant positive correlation was noted between the fasting blood glucose level and the degree of deviation from normal weight. Fasting pyruvic acid concentrations tended to be high in the overweight group.

Obesity in animals resulting from injury to the hypothalamus is characterized by a marked increase in food intake. It has been suggested that the hypothalamus may contain two centers that are concerned with regulation of appetite, a feeding center and a satiety center. Mayer [14] has proposed that activity of the satiety center may be controlled by some hormonal factor such as glucose in blood. Destruction of the satiety center may release the feeding center from inhibition with resultant hyperphagia. According to the glucostatic theory, the short-term regulation of food intake operates through glucoreceptors that may be situated in the hypothalamus, and perhaps also in the periphery, to maintain a constant "effective" level of blood sugar. Glucostatic control may operate even when alterations in blood sugar are within the accepted normal range and may reside in differences in utilization as reflected by differences in glucose concentration in arterial and venous blood. Beaudoin and associates [21] observed an increase in glucose tolerance in subjects with "active" obesity, that is, those who were accumulating fat, but not in "static" obesity. They suggested that the increased rate of disappearance of glucose from blood might be explained by either of two mechanisms, which are not mutually exclusive: (1) increased lipogenesis, or (2) decreased oxidation of fat and proportionately increased oxidation of glucose. In the light of the glucostatic theory of regulation of food intake, the increased amount of food ingested by obese individuals might be explained by the early onset of "metabolic hypoglycemia" and the transitory nature of satiety. Fryer and associates [22] studied capillary-venous glucose differences in obese young men receiving 1,800-calorie diets low in carbohydrates, protein, or fat. There was no correlation between the satiety value of the diets determined subjec-

tively and the concentration of glucose in capillary or venous blood or capillary-venous glucose differences. Thus the glucostatic theory was not confirmed but neither was it disproved.

The limited studies conducted in human subjects suggest that there may be several kinds of obesity and indicate a need for much more investigation of the metabolism of obese persons and of factors that regulate appetite. In some persons, consumption of large amounts of food seems to stem from habits developed in childhood. If the same amount of food is consumed as age increases, weight gain will result, due to a decrease in basal energy needs with advancing years and to a concomitant decrease in physical activity. Another cause of excessive food intake is psychic and emotional disturbances. Anxiety, depression, desire for attention, frustrations, and difficulties in adjustment to life situations may lead to increased food consumption. Endocrine disorders are only rarely etiological factors in obesity in man.

The importance of low-energy expenditure as a cause of obesity has received increased attention in recent years. Booyens and McCance [23] measured the energy expenditure in routine activities of a group of healthy subjects at the University of Cambridge. The caloric expenditure per square meter of body surface per hour for 22 male subjects varied as follows: for lying down, 24 to 48; for sitting, 27 to 53; and for standing, 29 to 62. Similar variations were found for such activities as shaving, washing, dressing, walking, and cycling. The energy expenditure of some of the subjects was more than 30 per cent below the average for the group. These findings confirm earlier conclusions of Edholm and associates [24] that metabolic rates for basal and relatively motionless occupations of some individuals differ widely from the average. Since a large part of the day is spent in sedentary activities, these differences can significantly influence total energy expenditure. It is of interest, however, that in these studies low-energy expenditure in sedentary activities was not necessarily associated with obesity or with a tendency to gain weight.

In another recent study [25] 15 women of normal weight were matched in age and occupation with 15 obese women, and physical activity was measured for one week with a calibrated pedometer. The obese women walked less than half as much as the nonobese controls, yet their own estimates of activity were as great or greater than those of the nonobese women.

Johnson and associates [26] studied two groups of high school girls, obese and nonobese, of similar height, age, and school grade. Although neither group engaged in much physical activity, the obese group was definitely less active than the nonobese. It was reported that the obese girls had lower caloric intakes than the nonobese; hence, inactivity was more important in the development of obesity than overeating. Beaudoin and Mayer [27] found that individual food-recording methods gave grossly inadequate mean caloric intakes in obese women whereas a research type of dietary interview indicated a greater calorie intake for the obese than for the nonobese. Accordingly, dietary histories must be interpreted cautiously in obese subjects.

There is much evidence that cessation or reduction of physical activity often initiates the obese state. Greene [28] reported that, of 350 obese adults, 67 per cent began to gain weight after a sudden decrease in activity; in most of these subjects, inactivity was due to a long illness and convalescent period.

As mentioned previously, the habits of modern living tend to lead to a more sedentary existence. The machine has replaced manual labor in large measure; transportation is usually by automobile, bus, or airplane; and even recreational pursuits have become largely sedentary. In conjunction with this, the mid-morning and mid-afternoon snack and the late afternoon and evening social gatherings so common in our present society add greatly to daily caloric intake.

Obesity is not the only nutritional problem in adults in our present prosperous society, although it is the commonest one seen in otherwise healthy persons. The physician encounters nutritional problems in many disease states. These problems relate to all nutrient factors: protein, carbohydrate, fat, vitamins, and minerals, as well as to calories. Among the many problems may be mentioned the increase in nutrient requirements in prolonged febrile illnesses and other hypermetabolic states, poor absorption of nutrients in numerous diseases affecting the gastrointestinal tract, and excessive loss of nutrients in renal and intestinal disorders. The biochemical changes that occur in metabolic disease result in serious nutritional problems, for example, the electrolyte disturbances in diabetic acidosis. Cirrhosis of

the liver, a not uncommon problem among the prosperous as well as among those in less favorable economic circumstances, appears to be due in large part to malnutrition. The abnormalities of liver function that develop in cirrhosis often initiate further nutritional disease. In chronic alcoholism, protein and vitamin deficiency syndromes are observed not uncommonly, although the latter seem to be less frequent since the enrichment of flour and bread was instituted some years ago. Figueroa and associates [29] attribute the present low incidence of pellagra and beriberi among alcoholics, as compared to some years ago, to the additional supply of B vitamins furnished in enriched white flour and bread.

Even in a prosperous community there are always a few who, due to poverty, ignorance, or idiosyncrasy, fail to obtain a diet that fulfills even minimal nutritional requirements. In nutrition clinics and hospital wards, classical deficiency syndromes such as scurvy, rickets, beriberi, pellagra, and ariboflavinosis are observed occasionally. In addition, minor clinical signs of nutritional deficiency and biochemical evidences of an insufficient supply of certain nutrient factors are encountered often.

Of increasing interest in recent years is the possible role of nutrition in some of the so-called degenerative diseases, those conditions that occur in association with the aging process. Attention has been focused on the high incidence of atherosclerosis and its complications, particularly coronary artery thrombosis, in prosperous population groups throughout the world. It has been suggested that dietary fat may be implicated in the pathogenesis of this type of cardiovascular disease. Since the complications of atherosclerosis, thrombosis and ischemia of the heart, brain, and kidney, represent one of the most important medical problems in this and many other countries today, extensive research on relationships between dietary fat, lipid metabolism, and atherogenesis is under way. The present state of knowledge in this area has been summarized in several recent publications.[30,31] Only a few of the important findings can be mentioned here. Experimental atherosclerosis, which resembles but is not identical with the human disease, has been induced in several species of animals by certain dietary and hormonal manipulations. Diets high in fat and cholesterol, diets furnishing protein that is low in sulfur-containing amino acids, diets deficient in vitamin B_6, and various other regimens have resulted in lesions of blood vessels and changes in serum lipid levels. However, coronary thrombosis with myocardial infarction as seen in man has been produced only rarely under these experimental conditions.

Epidemiologic studies in various parts of the world have indicated an association between the total fat intake of population groups, serum cholesterol levels, and the incidence of deaths from arteriosclerotic heart disease.[32,33] A correlation between intake of animal protein and deaths from arteriosclerotic heart disease can also be demonstrated.[34] Clinical studies over many years have indicated an increased incidence of atherosclerosis and coronary artery disease in association with diseases in which hyperlipemia and hypercholesterolemia are common, that is, in diabetes mellitus, myxedema, nephrosis, and the xanthomatoses. More recent studies show that levels of serum cholesterol and of low-density lipoproteins are correlated with the incidence of myocardial infarction, and also with each other.[30]

Recent investigations in human subjects on controlled diets have demonstrated that diets low in fat result in a decrease in serum concentrations of cholesterol and certain other lipids. Diets high in unsaturated fatty acids tend to lower serum cholesterol and other lipid levels while diets rich in saturated fats may increase serum lipid concentration.[35–38] The mechanism by which unsaturated fats influence lipemia and hypercholesterolemia is not understood. Absorption, destruction or excretion, utilization, storage, or synthesis may be involved. The factors in fats that are responsible for changes in serum lipid concentration are also unknown. The degree of unsaturation and the chain length of fatty acids, the content of "essential" fatty acids and of sitosterol and the substances present in the nonsaponifiable fraction of fat are all being investigated.

Several speculative hypotheses relating essential fatty acid deficiency to the atherosclerotic process have been formulated,[39,40] but to date these are not supported by substantial evidence. It is postulated that cholesterol is normally esterified with unsaturated fatty acids. When these are not available, esterification with saturated fatty acids occurs and these saturated esters are deposited in the intima of blood vessels. Inability to form arachidonic from linoleic acid may be involved. Since this process may be dependent

on pyridoxine, deficiency of this vitamin might have the same effect as essential fatty acid deficiency. It has been suggested that the American diet has changed in the past 50 years so that it contains more total fat and smaller amounts of essential fatty acids. This concept is not supported by available data.[30]

Of considerable interest are preliminary studies that indicate a relationship between lipemia and coagulation of blood.[30,41] Further investigation in this area should prove most worth while since thrombosis, rather than atherosclerosis per se, is the important clinical problem.

In spite of the many unknowns, the hypothesis that dietary fat is a factor in atherogenesis deserves extensive and thorough exploration. There is great need for basic research and also for clinical studies, particularly studies of long duration, to determine whether changing the amount or type of fat in the diet will limit the progress of atherosclerosis and its complications.

There seems little doubt that atherosclerosis is the result of a combination of many factors including heredity, sex, morphologic and chemical anatomy of the blood vessel wall, and arterial blood pressure, in addition to diet and the lipid content of blood. One must conclude, as did Page and co-workers,[30] that "the evidence at present does not convey any specific implications for drastic dietary changes, specifically in the quantity or type of fat in the diet, of the general population on the premise that such changes will definitely lessen the incidence of coronary or cerebral artery disease." In view of the prevalence of obesity, however, it would seem advisable for many persons to consume fewer calories, and, since dietary fat is the most concentrated source of energy, some reduction of fat intake will often be desirable.

The best nutritional advice that can be given to any population group, and fortunately in prosperity such advice can be followed, is to consume a varied, balanced diet that furnishes good protein from animal as well as plant sources, cereal and grain products, fruits and vegetables, and enough fat to fulfill the potential needs of essential fatty acids and to meet calorie requirements.

This brief summary of nutritional problems in a prosperous adult population has indicated that all types of malnutrition may be encountered, although the incidence of serious undernutrition and classical deficiency states is quite low. The most important problems appear to be obesity and nutritional abnormalities that occur secondary to disease. Increasing longevity and the prevalence of the so-called degenerative diseases in prosperous countries, particularly atherosclerosis and its complications, should stimulate nutrition scientists to search for the possible role of nutrition in these conditions, which at present are largely of unknown etiology. Nutrition has indeed come a long way in the past hundred years. The future holds great promise.

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Radiologic Visualization of the Spleen in Infancy and Childhood

Luisa M. Massimo, M.D., and Carla Borrone, M.D.

THE SPLEEN can be visualized radiologically by a number of methods, such as (1) direct examination, (2) indirect examination after visualization of the gastrointestinal tract, (3) indirect examination after intravenous pyelography, (4) hepatolienography, and (5) pneumoperitoneum. In the last few years important progress also has been made with retropneumoperitoneum[1] combined with axial transverse stratigraphy, a name given by Vallebona[2] to tomography.

Although renal diseases are the most important field for retropneumoperitoneum, the method can also be applied to investigating the spleen.[3,4] The association of retropneumoperitoneum with stratigraphy in its three projections—frontal, sagittal, and axial transverse—can be very useful in many cases.

Introducing radiopaque substances directly into the portal system was also found to be advantageous in radiologic study of the spleen. Good results have already been obtained in pediatric radiodiagnosis with a method proposed recently by Italian authors. The portal venous system can be visualized and studied after injecting radiopaque media into different vessels. The methods used included postmortem venography, venography during abdominal surgical interventions, and transparietal splenoportography.

Post-mortem portography was first studied by Caroli and others,[5] who classified subjects examined into two groups in relation to portal hypertension: 1. The patients of the first group, having extensive anastomoses between the portal and caval systems, do not develop ascites along with portal hypertension. 2. Patients in the second group, which has a much greater frequency, do not have sufficient collaterals and easily develop ascites along with portal hypertension.

Doehner and others[6] investigated 50 fresh adult cadavers, injecting the portal system with a barium-water mixture. Considering the portosplenic angle, they classified the subjects into three main roentgenologic types. They studied also the variations of the major tributaries and the diameters and lengths of the more important vessels. The same authors conducted further research in 40 subjects on the collateral veins and systems in the presence of intrahepatic block-type obstruction. They discussed the relationship of the collaterals to portal hypertension and evaluated the significance of these findings in relation to clinical portography.

Sansone[7] investigated the morphology of the omphaloportal system in cadavers of newborn babies. He emphasized the extraordinary polymorphism of the venous tree; his findings could explain some splenohepatic diseases of childhood.

Portography in vivo was performed for the first time in 1949 by De Sousa Pereira and others[8] in a patient undergoing appendectomy. Having injected 15 to 20 cc. of the opaque medium in the appendicular vein or in a small ileal vein, they could visualize the superior mesenteric vein and the portal system with its intrahepatic branches. Later on, they injected the opaque medium into a vein of the splenic ileum and succeeded in visualizing the splenic vein. In order to show the inferior mesenteric vein, they introduced the contrast medium into a small submucosal dilatation of a hemorrhoidal vein.

Actually it is possible to arrive at a manometric determination and make a phlebographic investigation of the portal system with a single needle communicating, through

Dr. Massimo is Assistant Pediatrician, Pediatric Hospital "G. Gaslini," University of Genoa, Italy. She interned at the Woman's Hospital of Philadelphia.

Dr. Borrone is Assistant Pediatrician, Pediatric Hospital "G. Gaslini," University of Genoa, Italy.

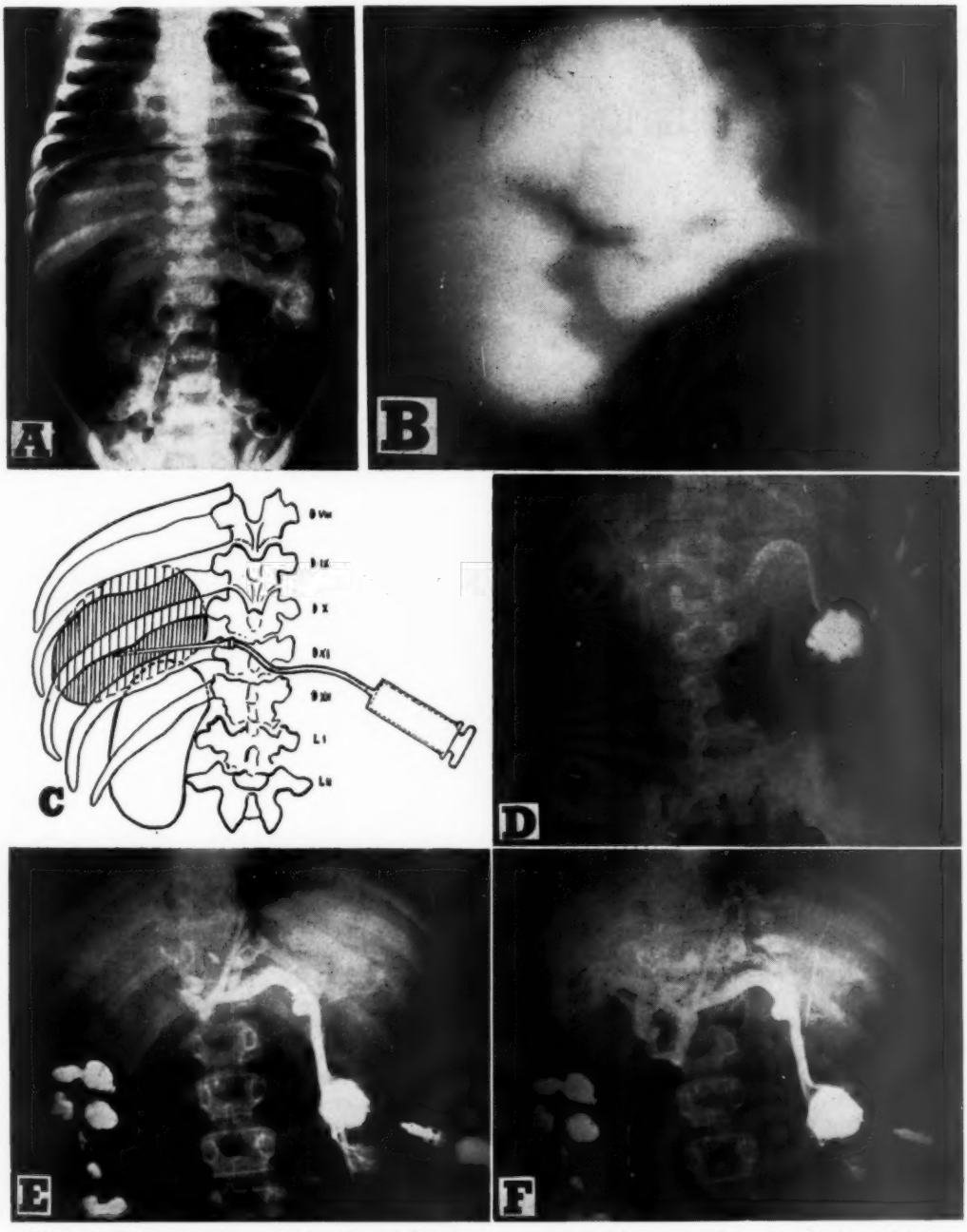

Fig. 1. (*A*). Roentgenogram of newborn baby in prone position. Liver and spleen are clearly outlined by pneumoperitoneum. (*B*). Tomogram of 8 year old boy. Axial transverse stratigraphy was done after insufflation of the stomach and retropneumoperitoneum (method of Sansone, Macarini and Oliva). This transverse section of kidneys, spleen, liver, and stomach clearly outlines the pancreas. (*C*) Schematic drawing of technique of transparietal splenoportography followed at our hospital. (*D*). Normal splenoportogram of 6 year old girl, with the intrahepatic branches well outlined. (*E*). Splenoportogram of 10 year old boy with hepatic cirrhosis, showing intrahepatic block. (*F*). Splenoportogram of patient in *E*, showing several collateral vessels, with minimal intrahepatic circulation.

a threeway stopcock, with the manometer and the syringe. The quantity of the opaque medium to be injected varies from 20 to 30 cc.; the introduction must be done rapidly within a few seconds. The first roentgenogram is taken at the end of the injection, the following ones after one and two seconds. While the roentgenograms are being taken, the anesthetist keeps the patient in apnea. This examination, performed only during surgical intervention, has a very limited application.

Remarkable progress was made with transparietal splenoportography, proposed by Abeatici and Campi in 1951.[9] The opaque medium was injected through needle puncture of the spleen. This technique appeared difficult to apply in the pediatric field, because cooperation of the patient is necessary in order to obtain apnea while the needle is being inserted into the spleen; a displacement of this organ could lead to dangerous tearing. This difficulty was overcome for the first time in our department by Sansone in 1953.

The technique, which is still used by us, consists of the following: Instead of connecting the needle directly to the syringe filled with the opaque medium, a strong but flexible rubber tube, 8 to 10 cm. long, is inserted between the syringe and the needle. In this way the needle is fixed only through the abdominal wall, while the part inserted in the spleen can follow freely the movements of the organ because the rubber tube allows any displacement to the opposite side.

When the spleen is pricked with the syringe-tube-needle, it is advisable to wait until the child becomes quiet, in order to avoid tearing the spleen. Ten to 15 cc. of opaque medium (Juduron, 70 per cent) is introduced in two to three seconds and serial angiograms are made, the first film being taken at the beginning of the injection, followed by others every two to three seconds. The last film is taken a few hours after the injection, in order to make sure that all the medium has been eliminated from the spleen.

In our department in the last few years, radiologic visualization of the spleen was largely applied in cases of Banti's disease, hepatic cirrhosis, and all types of portal stasis from extrahepatic or intrahepatic obstruction. A slight sense of tension referable to the spleen was the only reaction noted.

Sansone and Roscioli[10] made a study of the spleen of children splenectomized a few days after splenoportography, to see whether any macroscopic or microscopic alterations were present. In almost all these cases the authors demonstrated necrotic and hemorrhagic areas. For this reason, they advise use of splenoportography only when splenectomy is indicated. This procedure is important in making the right diagnosis and is helpful to the surgeon.

Today, with several techniques for visualization of the spleen, we can choose the one must suitable for each case, according to the different problems we want to solve. The usefulness and absence of risks in retropneumoperitoneum combined with stratigraphy must be considered first, while splenoportography can be used in particular cases. (see Fig. 1).

SUMMARY

The problem of the radiologic visualization of the spleen in infancy and childhood is considered. Various techniques for demonstration of the splenoportal system have been reviewed. Transparietal splenoportography, recently proposed by Italian authors, is described, and its usefulness in the pediatric field is emphasized.

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Problem of the Aged Patient in the Family

MAURICE E. LINDEN, M.D.

REARED AS WE ARE in a Judeo-Christian tradition that presumably observes the Fifth Commandment, honoring our elders, we must feel guilty and scandalized to a considerable extent to find that the aging and the aged are referred to as a "problem." If we abided by our principles, aging could hardly be more troublesome than any other segment of the course of growing up. But there is now cumulative evidence that points to the fact that ours is a youth-oriented society—a society in which most of the rewards of life are assigned to the young end of the scale. The later phases of living are treated as a barren anticlimax devoid of warmth, relationship, and meaning.

We even speak of aging as a social problem and a social problem as a rule is one for which public programs are devised. This means that an important proportion of the population has become so beset and affected by the cares and tribulations of living that the community as an organized body must design and provide methods, facilities, and personnel to furnish and administer specific antidotes.

But every social problem begins at the family level. Whenever we blame society we are in reality indicting families, which collectively make up society. We all have a stake in aging and all of us have contributed to its vicissitudes. In this sense we all have shared in exposing the aging and the aged to the many factors that almost everyone must experience if he lives long enough.

The outstanding elements in our society that affect the elderly, including social, physical, and psychological factors, are as follows: (1) orientation toward youth and change in our culture, (2) economic dependency, (3) social isolation and loneliness, (4) general lack of regard for the process of aging, (5) special health problems in the later years, (6) the natural physical and mental stresses of growing older, (7) failure—universally found—in emotional preparation for senior citizenship, (8) undeveloped capacity to utilize leisure constructively, and (9) lifelong psychological problems.

Overlooked as a rule are the following problems the elderly face: (1) the multiplicity of ways in which the younger generations are a problem to the aging, (2) the special problem of aging itself, (3) the manner in which many older persons are a problem to themselves, and (4) the ways in which the aging may be a problem to each other. Also overlooked is the fact that many older persons are no problem at all. Individuals in advanced maturity are social irritants mainly by default. Correction of a variety of social factors as well as vigorous administering to psychological needs can help restore the process of aging to its respectable and rightful position in the human life cycle.

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Dr. Linden is Director of the Division of Mental Health, Department of Public Health, Philadelphia, and Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine.

SOCIAL FACTORS

Retirement Stagnation. Many of our current social concepts create out of the later stages of life a superfluousness that may be termed "the outliving of usefulness." Retirement at a particular age is a comparatively recent development in social trends. In many individuals it constitutes a mandatory withdrawal from activity long before biological events would require it. The obvious emphasis in our society on the qualities and values of the

youthful periods of life tends to create an inadequate *raison d'être* in the later periods. The feeling of having outlived one's usefulness and the stagnation felt after retirement lead to social dependency. The need to fall back upon the charity and dubious generosity of the social milieu creates a state of dependency even among those who have hitherto enjoyed independence and self-sustenance.

While it forces idleness and dependency upon many of the aging, society has failed to make adequate preparations for the new and pressing needs that appear after retirement. In most instances both the individual and his community are indictable for such lack of preparation. The relative absence of facilities for productive and creative participation and activity in later senescence plays an important part in retirement stagnation.

Cultural Exclusion. A combination of events leads to the factor of cultural exclusion that may be termed the "discarding of the elders." The series of stages traversed by the developing individual contains progressive steps from infancy onward in the formation of an attitude of covert hostility toward the parental surrogates of the culture. These stages have been well documented in psychiatric literature: (1) a drive for autonomy of function in infancy and young childhood; (2) the interplay of erotic urges and the "will-to-power" with attendant envies, jealousies, and rivalries in middle childhood; (3) the urge toward gang and juvenile society formations in later childhood (designed to exclude the elders who are perceived as lacking in understanding and overimbued with regulatory authority); (4) the drive for self-expression and application of instincts in puberty (at which time the elders are viewed as arch prohibitors); (5) the ambivalent strivings for independence and self-assertion during adolescence (when elders are viewed with suspicion and treated with defiance); and (6) the aspirations to social success in the young adult stage (when elders are viewed as envied leaders against whom a drive toward replacement is not so subtly entertained).

It is clear that the body of social attitudes added together results in a pervasive cultural atmosphere of social rejection of the elders. The result of such rejection is isolation, both physical and emotional, of the older person himself.

Every individual possesses the need to maintain the continuity of familiar circumstances, or to re-establish it when it is broken. As the aged discover themselves in an isolated state and turn outside for psychological support, they encounter "lack of an empathic external milieu."

Society is not static during the early stages of self-isolation of the aged. Inevitable changes take place and attitudes grow cool and remote toward the aged. Simultaneously, death or relocation of former associates and affectionately regarded relatives account for a diminished circle of social contacts. Opportunities for emotional and ideational interchange diminish and increasing loneliness becomes the lot of many older persons.

Another basis for cultural exclusion is the recent shift from farm to city and suburbs. Apartments or apartment-like housing have become our residences. The outcome of this is a matter of daily experience; that is, the children have little place to play. Simultaneously, the arrival on the social scene of such entertainment devices as television has driven ever-increasing numbers of younger persons into the house where they naturally come into a variety of conflicts with the older persons who must compete with them for precious floor and living space. And, paradoxically, the common mode of television viewing, which should create congeniality, fosters loosely knit groups wherein each member's attention is glued to the object in completely detached isolation.

Sociologists also inform us that the city does not have a stabilizing influence on family life, at least at the present point of development of our country. At one time, the development of youngsters and their friendships and courtships were supervised and overseen by elders who acted as responsible authorities contributing to the guidance of their offspring in spacious and comfortable dwellings. But, today, the social life of the young generations, their courtships, their lovemaking, and their tribulations, in large measure take place outside the family household. In earlier days the cohesive and affectionally organized family group served as the problem-solving agency for the vicissitudes of its members; today, the family becomes the battlefield for problems.

Formerly, the family very often consisted of at least three generations living under one roof, a situation that is becoming a rarity today. Industrialization, the shift of population from the rural toward the urban community, the rising costs of construction, the

smaller available parcels of land, accelerated modes of communication and travel, the decreased size of families, early independence of family members, and other factors have produced a social setting in which there are essentially two forms of living arrangements—the two-generation home and the one-generation unit of the elders.

This latter development has brought about a need for greater independence in both segments of the family. The change is apparently not unwelcome. The younger family members are not averse to maintaining a respectable distance between themselves and the grandfather and grandmother, providing the latter remain on tap for special services. However, a recent poll of older individuals revealed that a great majority of them also prefer not to live with their children. This feeling is not necessarily due to lack of affection but is based apparently upon universal preference for independence in our society.

Discordant Value Systems. The outcome of the foregoing factors, such as the sense of outliving of usefulness and the feeling of being rejected, is the development of what we may call among older persons the "passé complex." This social factor is in actuality the experiencing of all the rejecting impulses of the earlier periods of life.

For the sake of simplification I should like to apply a coined term used in one of my earlier papers for what may be called roughly the first half of life—"evolescence." The later half of life may analogously be called "senescence." As a maturing individual reaches the later stages of his own senescence, the elder-rejecting impulses of his own evolescent period become turned against himself. He thus rejects himself. Such self-rejection is the very essence of the passé complex. Self-rejection really means hostility turned against oneself, and such self-directed hostility eventuates clearly in depression or melancholia.

If we consider, in addition, the inherent differences between evolescence and senescence, we find that the qualities of life and the value systems of individuals are quite different in these two periods. Briefly, it can be pointed out that many values of evolescence exclude and derogate those of senescence. The moral values of senescence consist, on the one hand, of a set of fairly altruistic attitudes toward individuals of the younger age levels and, on the other hand, of drives for self-survival. This leads to what may be called the "internecine strife between evolescence and senescence." In essence, this strife is highlighted by "change versus conservation." It is the very nature of evolescence to require change and what is often presumed to be progress. It is the nature of senescence, partly through the compulsion to sustain the familiar and partly through the dictates of wisdom as well as the philosophical comprehension of life intrinsic in the mature mind, to undertake to conserve essential social features of a culture which have withstood the test of historic time. In the growing conservatism of the elders there is an intrinsic logic, but it comes into sharp conflict with the drives and values of the "evolescents" who outnumber the elders and whose vigor is greater as well. On this account, drives toward change find greater acceptance and are more easily expressed in our society than attitudes of conservatism, which require constant defense and re-establishment of safeguards.

PSYCHOLOGICAL FACTORS

Normal Aging. Normal aging, which implies normal maturation, is not a problem in family life. The maturing adult, by virtue of his growing wisdom, increasing judgment, and diminishing aggressive instinctual drives, becomes progressively more altruistically disposed toward oncoming generations. He may as a consequence enjoy a status of affection and acceptance within the family structure.

In a culture that just tolerates the aged, or even in a setting in which older people are accepted, venerated, and assigned a felicitously symbolic and authoritative role, the process of aging is fraught with special burdens. It means an increased sense of responsibility, a heightened appreciation of reality, a greater feeling of sobriety, and an advancing obligation to make decisions. Many people entering the mature years are refreshed by the singularly challenging nature of the new set of experiences. Their personalities respond well to duty and they seem to grow stronger as the potential of their capacities and talents begins to be reached. They meet the challenge.

Abnormal Aging. Some individuals, beset by the vast assortment of mature obligations, lose heart early as their neurotic difficulties take precedence and prevent them from full attainment of their capacities in later maturity. Such people regress more or less quickly as their egos yield to unconscious pressures and

they are overwhelmed by formerly hidden feelings, memories, attitudes, and impulses.

Even for those who meet well the challenge of aging, there usually comes a time when the pressures of adult responsibility are relieved or removed. In contrast with the oft-heard profession of relief at such a turn of events, the lost responsibility is mourned by some elders. Since the loss usually is not or cannot be restituted, the grief and mourning proceed to a melancholic state. Archaic defensive systems, long in a state of hibernation, spring to the fore with renewed energy. The serial recession that follows through stage after stage of childish and infantile behavior patterns is now well known.

In many other instances the older family member may meet the emergencies and emotional deprivations of later life with a deeply hidden feeling of panic that is sensed as anxiety. The feeling of insecurity and the excessive concern thus generated drive the older person backward from independence to the need to cling dependently to every form of support. A feeling of dependency is usually rejected by people at any age level. A simple way of dealing with it, since its emergence is a *fait accompli*, is to deny it. The denial of a fundamental attitude requires that a covering system of behavior be utilized as a measure of effective disguise. One of the most practical of such measures is the employment of compensatory modes of acting. The compensatory measure for the feeling of dependence most apt to be used by many older persons is the development of a very firm, unyielding attitude of conviction regarding sundry social questions. In the family setting this is seen as rigidity. Whereas the normal aged mind has a certain orientation in conservatism, that attitude is quite different from the forbidding rigidity too often seen in senior members of our society. The rigidity of personality and the closed-mindedness it fosters are irritants in the emotional climate of family life. The two-way frustrations that grow out of them drive an ever-widening wedge of disparity between the generations.

It is important to note here that the progression of events in aging does not by any means always eventuate in senility or the mental illnesses of senility. In most instances the older person either ages in a fashion acceptable to those about him or utilizes systems of behavior and psychological devices that, although rendering him a problem to his environment in varying degrees of intensity, usually fall far short of that which would require his placement for care or treatment.

Attitude of Family Members. I have already mentioned briefly some of the attitudes of society that impinge upon the older member. One should also look into the emotional atmosphere that is prevalent within certain families.

Certainly one would hope that in the majority of instances the main attitude of other members of the family toward its aging and aged members is one of love. Interestingly enough, however, even the apparent feeling of love toward the elders may sometimes cause difficulties. Not infrequently, such love may generate a sense of protectiveness toward the elder, with the result that, when the aged parent or relative develops an emotional or physical illness requiring care in an appropriate hospital or institution, the family defers taking action until it is either too late or until the condition has become an emergency. The realization, whether conscious or unconscious, that one has rejecting and discarding impulses and aggressive and hostile drives toward close family members produces feelings of guilt. Guilt feelings as a rule are sensed as discomfort, uneasiness, and an inner sense of persecution. The common method of handling such guilt, in order to be rid of the unpleasant feelings, is to think and do things that have expiatory and penitential value.

The outcome of this is often an enormously exaggerated but usually inconsistent mode of behavior in which the elder is overindulged and catered to excessively. The further outcome, as in other situations that are more obviously laden with hostility, is increased dependency and emotional isolation and regression for the older person.

In spite of the fact that rejection of elders seems to be common to our culture, the mere fact that it is found on a broad scale apparently does not divest individuals of a feeling of guilt and embarrassment concerning it. The effects on younger people of their guilt feelings are serious enough, what with the sense of insecurity, inadequacy, tension, fear, and anxiety they foster; however, the older persons as well as the very young become the targets of many of the psychological mechanisms of defense that the middle group elaborate to combat their emotional discomfort. In this regard one wag has said that the main reason the old and the very young get along

so well together is that they have a common enemy.

The defenses against guilt are many. The commonest patterns directed toward the senior members usually show up as: (1) a vicious cycle of intensified resentment, (2) a transparently insincere, overly sweet mothering, (3) a cloying and obsequious overprotectiveness, or (4) an overwhelming show of concern. No matter how subtly contrived the masquerade, the underlying motive is not lost on the aged. At some level of consciousness, they feel the rejection, as do children and certain psychotics, and frequently oblige by rejecting themselves.

Effect on Other Family Members. It is also important to note that the guilt stemming from rejection of elders added to other factors of emotional stress in younger persons may be sufficient to tip the psychological balance toward breakdown. In this regard it is well to remember that when the older parent is suffering some of the discommodities of aging, the adult children are very frequently in their own involutional period. This, of course, is a period of particularly delicate balance with regard to reactions to stress. It is a period in which depressions and other psychotic reactions are common. Also not uncommon is the finding that institutionalization of elders, or the aged persons' improvement and recommended release from residential care, may occasion major mental disturbances in the adult children.

Another effect of the social rejection of the aged is the influence that this example of rejection of elders has upon younger people. As the youngsters witness the not infrequently cruel rejection of the grandparents by the adult children, they develop like intentions with regard to their own aging. This guarantees, of course, that the vicious cycle of rejection of elders will remain unbroken generation after generation.

Reduction of the older person's personality to ignominy and impotence is serious enough in itself, but its effect on subsequent generations is of still greater significance. It seems clear that the maintenance of the grandparent ideal as the fount of wisdom, the oracle of perfection, the source of love tempered with unwavering adherence to principle, and the keeper of the archives of knowledge is important in the creation of an ideal conscience in the child. It also seems clear that there is a strong possibility of real social danger and of potential damage to the development of children's personalities in any cultural system in which the elders are devalued. As the latter succumb to the pressures to which they are exposed and demonstrate a diminishing strength that tends increasingly toward social insignificance, they become the objects of mixed feelings of scorn and pity in the younger generations. This debasement of the elders' role as the model and symbol of authority has a tendency to diminish the importance of all authority. Simultaneously, it gives the young rebel the illusion of possessing greater personal strength than is actually his. This tendency produces in the representative of the oncoming generation a tremendously exaggerated, overdramatized, and grandiose self-concept. This "I am the master" illusion is a communicable disease. This is the concept that fundamentally is responsible for the scrapping of tradition in an entire social group and the embracing of a new system of belief founded on megalomania, willfulness, and a philosophy of pleasure (hedonism).

To the factor of debasement of the role of the elder there must yet be added another factor, which seems to grow out of two additional sociological elements. The advent of the industrial revolution with its cohort, the feminist movement, tended to defeminize woman as a mother figure and to emasculate to some extent the man as a father figure. In addition, there seems to be a tendency among a fairly large number of people to experience a kind of reversal of their personalities as they grow older, the woman becoming more masculine and the man becoming more feminine. The meaning to the younger generations of the exchange of psychological roles between the two sexes is that personal ideals and human relationships become inconsistent, confused, and perplexing. Lack of uniformity in leadership and degradation of the elders furnish more fuel for the heat of rebellion in younger persons and tend to reinforce their drive toward injudicious autonomy. It also should be mentioned that the exchange of sexual roles between the parents eventuates in the unconscious development in the child of covert homosexual attitudes and conflicts.

SUMMARY AND CONCLUSIONS

Of importance to a consideration of current concepts that relate to helping older persons

and preventing the indispositions of aging is the realization that many psychological problems in aging are social artifacts. They are very often products of misdirected human workmanship rather than the inexorable expression of biological change.

Those who treat older persons know that lost faculties cannot be restored. What is truly absent from the somatic machinery cannot be returned. A certain amount of psychological impairment or loss must be expected as a counterpart of physiological decline. However, it is toward the faculties in the aged existing in a state of eclipse that treatment should be directed.

All who work diligently with older persons have seen the recuperative powers many of them possess. When human warmth, a milieu of acceptance, high standard care, nourishing sustenance, skillful guidance, therapy of ills, and opportunities for social expression are applied, generalized improvement, moderate to remarkable, almost invariably occurs.

It is no great step in logic to conclude that what is reversible is also preventable. If consideration is given to the sole fact of the potential for improvement in the aged group, long regarded as unpromising recipients of care, then the conclusion cannot be avoided that the greater probability of promise should be found in mental and social hygiene measures applied earlier in life. Most prominent among the preventive factors needed is a positive change in social attitudes toward aging.

Need for More Physicians

As part of its program of raising money for medical schools, the National Fund for Medical Education has compiled information on the question, "How many doctors are enough?" Physicians of our generation, the Fund points out, can treat more patients faster than was possible a generation ago. The physician today can serve a larger number of people in a wider territory than was the case when transportation was slow and undependable. Modern drugs, too, reduce the time necessary for each call. A case of pneumonia, for example, once required 11 hours of medical care by a physician; now it requires about an hour and a half. However, the physician of today has more to do: A greater percentage of the population consults him and does so more often; regular checkups are common; and people today are more aware of medical science and get in touch with their physicians more quickly when they feel it can help them. Then, too, the area of employment for physicians has expanded. Physicians are employed by schools, industrial plants, governmental health agencies, and other places where formerly medical care was not available. Most important is the factor of our rapidly rising population. New medical schools, already operating or in the planning stage, can provide the facilities to increase the number of physicians by 3,500 a year. However, by 1975 this number will fill the need by only two-thirds, even if the objective is not to increase but to maintain the present ratio of one physician to every 730 persons. The question seems to be "How can we provide the tremendous amount of money necessary to train an adequate number of physicians for the country?"

Reprints of Medical Conferences

Verbatim transcripts of conferences of physicians in leading U.S. medical centers are available on a monthly basis to interested physicians, interns, and medical students. The conference-transcript program, begun in November, 1958, is sponsored by SchenLabs Pharmaceuticals, Inc., in association with *New Physician*, the official journal of the Student AMA. Each month the journal publishes a clinicopathological conference section, consisting of a transcript of a physicians' clinical conference, based on a case history and treatment of an individual patient. The special section presents a complete diagnosis followed by a discussion by the chief of pathology, attending physicians, and consultants. Reprints of the monthly transcripts may be obtained, free of charge, by writing to the Professional Service Dept., SchenLabs Pharmaceuticals, Inc., 350 Fifth Ave., New York City.

Hydrocortamate (Magnacort) and Neomycin-Hydrocortamate (Neo-Magnacort) Ointment in Dermatology*

BEATRICE H. KUHN, M.D.

NUMEROUS TOPICAL PREPARATIONS containing various corticosteroids are available for dermatological use. The purpose of this study is to evaluate the effectiveness of two preparations, hydrocortamate (Magnacort) and neomycin-hydrocortamate (Neo-Magnacort), in relation to other topical steroids now available for general dermatological therapy. Both preparations contain 0.5 per cent 17-hydroxycorticosterone diethylaminoacetate hydrochloride as the active ingredient and the latter also contains 0.5 per cent neomycin sulfate.

Dermatological conditions treated include atopic eczema, chronic eczematoid dermatitis, congenital ichthyosis, dermatitis repens, dermatitis venenata, dyshidrosis, erythema intertrigo, exfoliative dermatitis, herpes zoster, keloid, lichen simplex chronicus, neurotrophic dermatitis, nummular eczema, recurrent herpes simplex, seborrheic dermatitis, secondary infections, stasis dermatitis, and sun sensitivity (actinic dermatitis).

*The material used in this study was supplied through the courtesy of Pfizer Laboratories, Brooklyn, N. Y.

Dr. Kuhn is Acting Chief, Department of Dermatology and Syphilology, McMillan Hospital, Charleston, W. Va., and on the active visiting staff, Memorial Hospital, Charleston.

STUDY

One hundred consecutive patients were used in this evaluation. There was no selection as to age, sex, race, or severity of condition. The ointments were used for periods varying from 1 to 12 weeks and applied to all affected areas four times a day.

RESULTS

Forty-seven patients were treated with hydrocortamate. Of these, 41, or 88 per cent, showed improvement, with 31 (66 per cent) showing excellent results. Six, or 12 per cent, were listed as failures. No steroid rebound was noted in any of the patients, although there was an 8 per cent relapse rate following termination of hydrocortamate therapy. The average duration of treatment was 2.2 weeks. Nineteen of the 47 patients with similar previous flare-ups had been treated with one or more other topical preparations containing steroids. Fourteen, or 74 per cent, responded as well or better to hydrocortamate than to other preparations used. Five, or 26 per cent, showed superior results with topical steroid preparations other than hydrocortamate.

Of the 53 patients treated with neomycin-hydrocortamate, 48, or 91 per cent, showed improvement, with 30, or 56.6 per cent, showing excellent results. Five, or 9.4 per cent, were listed as failures. Although a relapse rate of 15 per cent was found, no steroid rebound effect was noted with neomycin-hy-

drocortamate. Twenty-two of this group had previously been treated with other topical steroids. Eight, or 36 per cent, showed better response to other compounds, but 14, or 64 per cent, showed an equal or superior response to neomycin-hydrocortamate.

DISCUSSION

A study of 100 cases represents too small a sampling for purposes of statistical analysis. However, it is interesting to note that in a study of 549 cases treated with hydrocortamate [1] 493, or 89 per cent, showed improvement, compared to 88 per cent in this series. In a similar group of 132 patients treated with neomycin-hydrocortamate,[1] 92 per cent effectiveness was reported, compared to 91 per cent in this series. Since results in other studies are comparable, it is reasonable to assume that the present series has clinical validity.

Intolerance to neomycin-hydrocortamate was noted in 3 cases as manifested by erythema, burning, or vesiculation. All patients were subsequently able to tolerate hydrocortamate, thus identifying neomycin sulfate as the offending agent.

The relapse rate for neomycin-hydrocortamate was 15 per cent, that for hydrocortamate 8 per cent. No clinical significance can be attributed to this difference since the etiological agent was still active in all cases; thus the patient was subject to relapse regardless of the therapy employed.

The average duration of treatment for neomycin-hydrocortamate was twice that for hydrocortamate. However, 1 patient had been treated for three months with neomycin-hydrocortamate because of a keloid, thus producing this apparent disparity of effectiveness between the two drugs.

SUMMARY

Of 100 consecutive dermatological patients treated with hydrocortamate (Magnacort) or neomycin-hydrocortamate (Neo-Magnacort), 88 per cent treated with hydrocortamate and 91 per cent treated with neomycin-hydrocortamate showed improvement. The over-all relapse rate was 11 per cent, but this occurred only in cases in which the etiological agent remained active. Three, or 6 per cent, of the cases developed a reaction due to neomycin sulfate.

It is the author's belief that both preparations are a safe, effective form of topical steroid therapy.

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1. Personal communication to Charles Pfizer & Company, Inc.

Antibiotic Symposium

World medical authorities celebrated the thirtieth anniversary of the discovery of penicillin at the opening of the Sixth Annual Symposium on Antibiotics held in Washington, D.C., in October. Dr. Félix Martí-Ibáñez, Professor of the History of Medicine, New York Medical College, traced the development of the life-saving drugs from Sir Alexander Fleming's discovery in 1928 through the "broad-spectrum" era, which began 10 years ago, in 1948.

Great achievements in antibiotic medicine are no longer the result of a lone investigator working in the quiet of his laboratory but the consequence of team efforts, Dr. Martí-Ibáñez told the scientists.

Had antibiotic discoveries occurred at an earlier stage of civilization, they would have altered the course of history, Dr. Martí-Ibáñez said, citing catastrophes that might have been averted.

A preventive or prophylactic role for antibiotics in future medicine was predicted by Dr. Martí-Ibáñez. "In the medicine of tomorrow the role of antibiotics will become increasingly more prophylactic, as the interval between discovery of a drug and its clinical application becomes shorter and shorter. For a long time mankind was deprived of the benefits of many drugs simply because it failed to use them until long after their discovery . . . the sulfonamides, discovered in 1908, were employed only 27 years later; isoniazid, discovered in 1912, was not applied until 40 years later; and penicillin, discovered in 1928, was not used until 13 years later. These delays were often caused by fear of toxicity. It is now high time to convince ourselves that a drug's toxicity often runs parallel with its therapeutic activity, demanding not its rejection but merely greater precision in its use."

Maternal and Child Assistance in Chile*

GRACIELA MARTÍNEZ DE LEON, M.D.

IN ORDER TO UNDERSTAND the importance of the legal protection given today to mother and child in Chile, it is well to know the history of its development, made through important laws. Therefore I should like to describe the maternal and child assistance program and the history of its development. I would like to stress the fact that these laws are in actual operation and that their application is vigorously enforced by the State.

MATERNAL ASSISTANCE

Every pregnant woman from the time of conception has a right to free consultation.

Prenatal Period. This type of medical care is mainly of a preventive nature, in order that the mother be in the best condition for development of a healthy fetus. With this in view, obstetricians and midwives make regular professional examinations; milk and vitamin supplements are provided; and medical treatment and drugs are given to the sick, including hospitalization if necessary. A dental service is also included.

Social and economic help to indigent women is considered very important. Special homes have been established for unmarried pregnant women and attempts made to provide a job for the mother after delivery.

The mother who works receives other benefits. She is freed from heavy, nocturnal, or overtime work and does not work for six weeks prior to and six weeks after the birth of the child, although she receives her full salary, called the "maternal subsidy."

During the time the mother nurses her child, she receives "lactation help," which is equal to a quarter of her salary; this may be extended for the first six months of the child's life. A prenatal plan, created two years ago, consists of monetary help, readjusted periodically to the cost of living, which is given from the sixth month of pregnancy onward to the working woman or working man's wife.

The pregnant woman cannot be discharged from her job until 10 weeks after delivery.

Labor. Professional services are given in maternity clinics, hospitals, or at home.

Postnatal Period. The woman continues to receive the same benefits she had during the prenatal period. In addition to the maternal subsidy, she receives a final medical examination about 40 days after delivery.

CHILD ASSISTANCE

From birth until he is 15 years old, every child has a right to completely free medical care provided by the State. This service includes: (1) preventive medical care through health examinations, immunizations, provision of milk and vitamins, and health education; (2) curative medical attention in hospitals and clinics, with necessary medicaments given free; (3) preventive and curative dental care; and (4) social attention. This last benefit includes care in foster homes and in special establishments for children with behavior problems or irregular situations (orphans, sons of tuberculous parents, and so on). When a factory or any institution employs more than 20 women on its staff, it must provide a nursery where children under 1 year of age may be brought. A strict set of rules allows the mother time enough to feed and take care of her baby during working hours.

Finally, there is economic help, known as "family assistance," which is given to any man or woman for every child, legitimate or not, until the child is 21 years old (23 if he is a student).

HISTORY OF MATERNAL AND CHILD HEALTH ASSISTANCE

Before 1924 maternal and child assistance was entirely of an emergency nature and was given by private institutions. This assistance was mainly to the indigent members of the

*Presented at the VI Congress of the Pan American Medical Women's Alliance, Miami, Fla., on April 15, 1958.

Dra. Martínez is Resident Pediatrician, Children's Hospital, Valparaiso, Chile, and Director of the Pediatric Society of Valparaiso. For the last two years she has served as Pediatric Supervisor, National Health Service, for several of the provinces.

population, and the State neither organized nor controlled it.

In 1924 a new law, Obligatory Workmen's Insurance (No. 4054), was created, to benefit the working population, which, for the first time, had to co-operate actively in its own medical and social help. This law created an organization whose function was to provide the workmen with medical attention, a subsidy in case of sickness, and a regular income for their widows, for the old, and for the handicapped.

The law also provided that the working mother receive medical attention during the prenatal, delivery, and postnatal periods; economic help of one half of her salary for the two weeks before and the two weeks after labor; a quarter of her salary until the eighth month after the birth of her child; and medical attention, including drugs and food. She nursed the child for the eight months.

In 1936 the service was extended to include assistance to the child up to 20 years of age, and in 1937 the maternal benefits, which reached only the working woman, were extended to the workman's wife and her children. Afterwards, a home for unmarried pregnant women was established.

In 1931, with the passing of the Sanitary Code, the State became responsible for maternal and child protection in Chile, which, until that date, had been provided by private institutions and was dependent on the Obligatory Worker's Insurance Law. (Because of our constitution setting up Chile as a Unitary Republic, the law is for the whole country without any provincial differences.) This Code provided that every woman, from the beginning of pregnancy through delivery and the post-partum period, would have a right to State care. The child has the same right until he is past school age. Service consists of preventive and curative medical care, dental care, and social welfare service.

The maternal and child assistance program was administered by the State through the secretaries of health, education, justice, and others. The service was reorganized in 1942 into one department, called "General Direction of Child and Adolescent Protection" (DFL 201412). In this way, the protection of the population was improved. The mother is attended from conception to the end of lactation, and the child, including those with special needs, is assisted until adolescence.

In the same year, 1942, an agreement was made with the United States of America to improve public health, stressing environmental hygiene and mother-child protection. The American Cooperative Institute for Public Health was then created, and the Sanitary (Health) Units were organized, incorporating into them several different divisions.

In 1948 a change was made in the Work Code, creating a compulsory maternal rest period of six weeks before and six weeks after childbirth with complete salary, forbidding the dismissal of pregnant women, limiting heavy work, and creating nurseries.

The National Health Service (Law No. 10383) was created in 1952. This service combines all the State institutions and a few of provisional nature. Its functions are promotion, protection, and improvement of health. In order to accomplish this task, the Service operates clinics; general and maternity hospitals, the latter with specialized services for the newborn and premature baby; and sanatoriums and asylums for children with special handicaps or behavior problems. Its services are given to approximately 60 per cent of the population; nowadays, it maintains the maternal and child care program described at the beginning of this paper.

It is understandable that such an extensive program, which in all probability will become still bigger as time goes on, should be extremely expensive for the economy of a country like ours. The financing of these plans is sponsored in part by the national budget, in part by other institutions, and, finally, by the taxpayer. The maintenance of this measure and each one of the successive steps has been reflected in a small but definite percentage of the cost of living. Our only justification for these expenses is our fight to sustain and improve our standards of living and health. It is estimated that we have 100,000 abortions annually and 7,500 stillborn infants; that 774 mothers die each year during pregnancy, labor, or immediately afterward; and that 27,500 children annually do not reach 1 year of age. In view of these impressive figures, the legislators did not hesitate to provide the necessary means to help the people, trying to break through the circle of ignorance, indigency, sickness, and death. When I refer briefly to the maternal and child care program in Chile, I point to only one of the chapters of this struggle—the one that means most to me because it tries fundamentally to protect the child, the man of the future.

CASE REPORT

Unusual Post-Partum Rectal Bleeding

EVA R. SARGENT, M.D., AND EUGENE P. SALVATI, M.D.

BECAUSE POST-PARTUM rectal bleeding is such an unusual complication of pregnancy, the following case is presented.

REPORT OF A CASE

A 26 year old woman, gravida III, Para II, delivered a 9 lb., 13.25 oz. normal baby on March 7, 1957, by low-forceps delivery at Muhlenberg Hospital, Plainfield, N. J. A right median lateral episiotomy was used, which was extended by a tear. The episiotomy was sewn with 00 chromic absorbable surgical suture, and care was taken not to go through the rectal mucosa.

The patient had several attacks of diarrhea and rectal pain during the last two months of her pregnancy for which she visited my office (E.R.S.) three times a week with the belief she was in labor. After delivery her hospital course was normal. The red blood cell count was 3.63 million per cubic millimeter and hemoglobin level 76 per cent on the day following delivery. There was the average amount of discomfort in the area of the episiotomy post partum, and of rectal tenesmus and gas throughout the abdomen. She was discharged on the fifth postoperative day in good condition.

On March 16, 1957, nine days post partum, the patient telephoned, stating that she had passed about 12 large blood clots from her rectum, preceded by rectal pressure during the night. On examination in the office, the rectum was full of dark blood and clots, which, when removed, filled a large sputum basin. Blood was visualized as high as the rectosigmoidal junction. No bleeding area was seen nor mass felt in the rectum. There was average tenderness in the area of the episiotomy. The patient was admitted to the hospital as an emergency and immediately seen by a proctologist.

Insertion of the sigmoidoscope to 8 in. showed blood present in the lower bowel beyond the speculum. At this time no point of bleeding was found. The patient received a transfusion of 500 cc. of whole blood because of the excessive loss of blood and mild shock, in spite of the fact that on admission the hemoglobin level was 76 per cent and the red blood cell count 3.76 million per cubic millimeter. Bleeding stopped, and examination by barium enema two days later was negative, as were daily digital examinations, except for tenderness anteriorly. Five days later there was a slight amount of bleeding; anoscopy at that time showed a suture anteriorly, in the region of the episiotomy, which either had eroded through the rectal mucosa or had been placed through at the time of episiotomy repair. Bleeding was present at both ends where the rectal mucosa was penetrated. This suture was cut and the patient immediately noted relief from tenesmus. It was felt that a suture had been put through an internal hemorrhoidal vessel and that it had sloughed off—hence the bleeding. There were no further episodes of bleeding and the patient has remained in good health.

Dr. Sargent is Assistant Attending, Department of Obstetrics and Gynecology, Muhlenberg Hospital, Plainfield, N.J.

Dr. Salvati is Assistant Attending, Department of Surgery, Muhlenberg Hospital, Plainfield, N.J.

COMMENT

Extensive library research was done for literature on post-partum rectal bleeding. The only article that could be found was by Feigen,[1] who states that "serious rectal hemorrhage may originate at or near the mucocutaneous line—lesions can be obscured with the rectum full of blood. Finding blood in the sigmoid may indicate that a reverse peristalsis mechanism is involved."

SUMMARY

In this case of post-partum rectal bleeding, an unusual complication of pregnancy, a suture either eroded through the rectal mucosa or had been placed through at the time of episiotomy repair.

REFERENCES

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Medical Briefs

POLYOMA VIRUS PREVENTS TUMOR DEVELOPMENT IN HAMSTERS

Two National Institutes of Health scientists have reported that development of tumors induced in hamsters by the polyoma virus has been prevented by an immunizing agent prepared from polyoma virus.

This finding was disclosed in a paper by Dr. Sarah E. Stewart, National Cancer Institute, and Dr. Bernice E. Eddy, Division of Biologics Standards, National Institutes of Health, Public Health Service. The paper, "Tumor Induction by Polyoma Virus and the Inhibition of Tumors by Specific Neutralizing Antibodies," was presented by Dr. Stewart at the 86th Annual Meeting of the American Public Health Association in St. Louis.

Hamsters were injected with the immunizing agent when 2 days old and then again when 8 days old. When subsequently challenged with live virus two weeks after the second immunizing injection, 97 per cent of the hamsters did not develop tumors. Sixty-seven per cent of the unimmunized control litter mates that received the same virus challenge died with tumors within five months.

Drs. Stewart and Eddy reported about two years ago their discovery of a mouse tumor agent that is carried in tissue culture and has biological and physical properties of a virus. This virus produces multiple tumors in randomly bred and inbred strains of mice, Syrian hamsters, rabbits, and rats, if the animals are inoculated at a very young age.

Commenting on the results reported today, Dr. Stewart said, "These studies with animals are preliminary in nature and are not applicable to human cancer. At present, we have no evidence to show the implications of this work for the prevention of human cancer. Extensive research is necessary to find out first whether human cancer is induced by viruses."

Dr. Eddy, in a separate presentation, reviewed her work and Dr. Stewart's on the characteristics of the SE polyoma virus. The paper was entitled, "Characteristics of the SE Polyoma Virus, a Virus That Induces Malignant Tumors in Mice, Hamsters and Rats and Benign Growths in Rabbits."

PLASTIC SPEEDS BONE FRACTURE RECOVERY TIME

A plastic material which permits weight-bearing on fractured bones in 48 hours was described to the meeting of the American Association for the Surgery of Trauma, held in Chicago, by Drs. Michael P. Mandarino and Joseph E. Salvatore of the Hahnemann Medical College and Hospital.

The liquid plastic—a polyurethane polymer known as Ostamer—appears to form a chemical bond with the bone surfaces to be bridged, filled or strengthened, becoming an "intimate part of the bone," the Philadelphia surgeons said. "It is this property that differentiates it from glue, adhesive or common cement-type bonding."

Thus far, Ostamer has been used on half a dozen human patients, "with satisfactory results." Clinical use followed extensive animal experimentation. Up to now, it seems to meet the tests of "strength, osteogenicity, nontoxicity, cohesiveness and ease of handling during surgery."

Other clinical uses of the polymer include two cases of tibial nonunion, one supracondylar femoral nonunion and two pathologic femoral fractures.

Extensive toxicity and metabolic investigations have thus far shown no adverse reactions to Ostamer, Drs. Mandarino and Salvatore said. "The specimens observed to date show only minimal foreign body reactions and no evidence of carcinogenesis."

At the time of surgery, the polyurethane polymer is mixed with a catalyst, producing a rigid sponge-like compound with 7-10% cellularity. Since the compound is in liquid form, it can be poured onto as well as into the bones to be repaired. As it hardens, it forms a dense, rigid cellular foam. (From *Medical News*, Oct. 20, 1958.)

MATERNAL MORTALITY

The maternal mortality rate in the United States has declined 93 per cent in the last four decades. One maternal death occurs in about 2,300 live births today. In 1915 it was 1 for each 165 live births.

President's Message

The New Year has started and, with it, I am sure, many resolutions and promises of a new beginning. Since promises and resolutions are too easily broken, perhaps a re-evaluation of one's life situation is more valuable. Such a re-evaluation has been attempted in regard to the American Medical Women's Association and we have made more than a good start.

The program at the midwinter meeting was excellent, both in content and presentation. The Planning Committee of the local branch, in co-operation with the Program Committee of the AMWA, is to be congratulated. The selection of place and the details of arrangement, including the beautiful flowers for each luncheon and dinner, represent many hours of work by members of Branch One, to whom we are very grateful. The music of the Marine Band, the invocations given by three different members, and the able services of the parliamentarian all set the stage well for the business sessions.

At the business meeting plans presented by the Executive Committee were approved. This means that the program will be further developed and extended. The preceptorship plan is being studied. A pamphlet by the Chairman of the Medical Education Committee for high school students has been ordered. A new junior branch and a new regular branch have been organized and chartered. Others are in the process of reaching this final step. The Library Fund is growing and needs a final boost to reach its goal. All this activity indicates a new stirring within the organization, which is essential for growth. For such a future, each one is needed and is invited to participate. As stated by Theodore Roosevelt, "Every man owes part of his time to the building up of the industry or profession of which he is part. . . ."

In closing may I say that without the efficient work and untiring efforts of our professional staff the achievements that I have enumerated above could not have been accomplished. To them and to you, I wish a happy new year.

Katharine W. Wright

Branch News

Problems of the Adolescent were discussed by a panel of four at BRANCH Two's (CHICAGO) January, 1959, dinner meeting. Contributing to the discussion were a social worker, a psychiatrist, and the founder of a local social center. The panel was moderated by Dorothy Welker, M.D.

AMWA Past-President Esther C. Marting, who represented the Association on the tour of medical institutions in Russia last year, will speak on Medical Care in Soviet Russia at the February meeting of the Branch. Discussion on this topic will be carried out by Drs. Carroll L. Birch, Augusta Webster, and Katherine Wright.

Studies of Infertility will be presented in April by Drs. Eloise Parsons, Helen Button, Daniel H. Callahan, Jr., and Katherine Wright, and the final meeting of the year, in May, will feature installation of officers and committee reports.

The October, 1958, joint meeting with the Women's Bar Association and Administrative Women was concerned with a "New National Interprofessional Code for Lawyers and Doctors" and "Career Guidance." "Diffuse Pulmonary Disease" was the topic of the November, 1958, meeting, with Drs. Bertha L. Isaacs, Elizabeth A. McGrew, Flora Brown Wurtz, and Gazella Albrecht participating, and a Christmas party was held in December.

An attractive green folder describes the Branch's programs for the year; Branch officers and committee chairmen are also listed.

At the fall meeting of BRANCH EIGHTEEN (NEW YORK STATE), held under the chairmanship of Dr. Gertrude Felshin, Dr. Annabel B. Miller, Chief of the Department of Pulmonary Diseases at the Veterans' Administration Hospital in Buffalo, delivered a stimulating paper on "The Use of Steroids in the Treatment of Pulmonary Diseases." Dr. Lucy F. Squire, radiologist at the Strong Memorial Hospital in Rochester, illustrated her discussion of the radiologic aspects of Dr. Miller's paper with roentgenographic films.

Preceding the scientific session and business meeting was a luncheon at which members of the Branch continued long-standing friendships and became acquainted with newer members. In the evening members gathered at the home of Dr. Lucy F. Squire for a supper at which Dr. Harriet Northrup, Chairman of the Program and Arrangements Committee, was cohostess.

At an October dinner meeting, Branch TWENTY-FIVE (PHILADELPHIA) members heard "Impressions of Soviet Medicine" formed by Dr. Leona Baumgartner, Commissioner of Health in New York City, during the recent tour of medical institutions in Russia in which 12 U.S. and Soviet women physicians participated on an exchange basis. Dr. Baumgartner's presentation was preceded by the Woman's Medical College Alumnae dinner and reception.

Women medical students, interns, residents, and local nonmember medical women were guests of BRANCH FORTY-SEVEN (COLORADO) at a dinner in October, at which lawyer Victoria Cross spoke on "Crosstides in Adoption" from the national and local angles.

Earlier in the month Dr. Virginia S. Lanier entertained the women medical students of the University of Colorado Medical School at a brunch in her new home. The brunch, described as "delightful," was also attended by Branch officers and several members.

MEMORIAL TO MARION HILLIARD (1902-1958)

Dr. Marion Hilliard, born in 1902 at Morrisburg, Ontario, died in Toronto on July 15, 1958, at the age of 56.

For 27 years Dr. Hilliard was associated with the Women's College Hospital in Toronto, and for the past 10 years she was chief of the Obstetrics and Gynaecology Department. In July, 1958, she was to have been inaugurated as president of the Medical Women's International Association.

During her years at the Women's College Hospital, Dr. Hilliard had a full-time, heavy private practice, but at all times she was on hand to help her colleagues and to be the leading figure in the development of the hospital. She had a schedule with which no one else could cope, and yet no problem of any clinic patient was too small for her consideration. Her answer would be given in a manner that suggested she had all the time in the world. She loved people, and had a depth of humanity that words cannot convey.

Each patient who went to Dr. Hilliard's office came away feeling that she was the only patient who mattered, and that she had received not only sound medical advice but also the valuable experience of meeting a member of her own sex who had a deep faith and the right to give counsel. Dr. Hilliard made patients realize that life was complicated but that it held a real challenge that each one should accept and could overcome.

Seriously ill patients in the hospital were given sympathy but also the courage to fight. Dr. Hilliard had a wonderful smile and a warm, vibrant voice that could change the entire day for a patient. Each one knew instinctively that everything would be all right when her care rested with this doctor friend.

Because of her ability to help women, Dr. Hilliard, in 1952, began a series of articles in a Canadian magazine on women's problems. These subsequently were compiled in "A Woman Doctor Looks at Love and Life." Women in Canada and the United States who had not had the privilege of being her patients benefited from her writings because she wrote as she talked. She had sound convictions and the courage to put them in print.

In January, 1956, Dr. Hilliard was the recipient of a trust fund. Patients from all over the world contributed to this unique fund, which was to be used in the Women's College Hospital as she so desired. The tribute that accompanied this honor was written by a patient and read as follows: "A tribute to Marion Hilliard, physician and friend, whose skillful hands have been the world's first sure strong cradle for thousands of babies born in her care; whose understanding yet challenging voice has spoken wise counsel, replacing ignorance with knowledge and fear with courage, for thousands of women who have been her patients; whose love of life and of her God has been her freely communicated gift to . . . her church, her country, and her world."

Medical women who have profited by her friendship and guidance, and by her teaching that medicine is an art as well as a science, are feeling her loss more deeply each day. She gave them the courage to overcome the difficulties of practice, to give to their patients hope as well as medical care, and, finally, to function as warm, friendly women.

Dr. Hilliard died as she lived. Her great faith was apparent throughout her illness and she continued to help her friends to the last day. Those who knew her realize that her every moment had been lived joyously and vigorously and that no job was left undone.

—Dorothy E. Daley, M.D.

Of Special Interest

FIRST CANADIAN WOMAN AMBASSADOR

The first Canadian ambassador to Israel is also the first woman to be appointed as a Canadian Ambassador. It was announced in September that Miss B. Margaret Meagher, who has been serving as chargé d'affaires in Israel, had been appointed to the post of ambassador there.

RESEARCH FELLOWSHIP STIPENDS RAISED

The Public Health Service and the National Science Foundation have announced an increase in stipend rates for research fellowships. The stipends were increased after scientists surveyed in training centers throughout the country supported the move as necessary to sustain the research training programs sponsored by the two Federal agencies in non-Federal, nonprofit research institutions. Allowances for dependents of $500 each will be made for fellowships on both predoctoral and postdoctoral levels; travel expense and research supply allowances will remain unchanged. Public Health Service fellowships are awarded in health, medical, and related sciences, while National Science Foundation fellowships are awarded in sciences.

REVISED POLICY FOR PATENTS

Policies governing patents have been revised for products or processes that may be developed by private industry under Government cancer research contracts. Announced recently by the Department of Health, Education, and Welfare, the new policies are designed to protect the public interest and at the same time to safeguard the rights of private industry. It is expected that under the revised procedures industry will participate in the effort to develop anticancer agents. The policy permits an industry to patent and sell drugs or other chemical agents developed under Government contract research. Only if necessary to the interests of public health would the surgeon general of the Public Health Service have authority to license other manufacturers to produce the patented agents. Under the recent policy statement, the surgeon general would maintain close consultation with the contracting company to apprise it of public needs and to assure the producer of a reasonable opportunity to meet them.

In commenting on the revised policy, Dr. John D. Porterfield, Acting Surgeon General of the Public Health Service, said: "Full and effective participation by industry is essential to the success of the growing nationwide program to develop and test thousands of chemical compounds for anticancer activity. When industry accepts a Government research contract and devotes its scientific knowledge, facilities, and personnel to this field, it quite properly expects a reasonable opportunity to protect its investment and rights to produce and use a chemical or other agent derived from its own research efforts. On the other hand, if the Government finances all or part of such industrial research, Government has a responsibility to ensure that the products of that research are generally and promptly available in a manner that meets the public interest."

During fiscal year 1958, a total of 25 million dollars was appropriated by Congress to the National Cancer Institute for the cancer chemotherapy program. Most of the funds were used for grants and contracts to support research in medical schools, universities, and other nonprofit research centers. Over 4 million dollars was utilized for 17 research contracts with 13 chemical and pharmaceutical houses.

A significant expansion of industry's role in the cancer chemotherapy program is planned during fiscal year 1959. The Congress appropriated almost 30 million dollars for cancer chemotherapy, of which 10 million dollars will be used for research contracts with industry.

Opportunities for Women in Medicine

AWARDS

Medical History Essay. The William Osler medal, offered by the American Association for the History of Medicine in honor of Sir William Osler, is awarded for the best unpublished essay on a medicohistorical subject. Students in medical colleges in the United States or Canada are eligible for the annual award. The prize-winning essay may be considered for publication in the *Bulletin of the History of Medicine*, the official organ of the Association. The essays, not to exceed 10,000 words in length, should demonstrate either original research or an unusual understanding of a problem in medical history. Competitors are expected to use only sources available to all contenders, such as libraries and museums, and to seek help only from faculty advisers. Students may submit essays at any time up to the next entry date after graduation. Essays may be submitted before April 1, 1959, for the present contest, to Dr. Samuel Radbill, 7043 Elmwood Ave., Philadelphia 42.

Student Essay Competition. The *New England Journal of Medicine* announces its 1959 essay contest for fourth year medical students, with prizes of $150, $50, a subscription to the *Journal*, and consideration of the winning manuscript for publication in the *Journal*. The editors are interested in encouraging good medical writing; therefore, "particular attention will be paid to clarity, simplicity, and general literary excellence." Competing essays, to be based on a clinical case studied by the writer in the course of her academic work, should include a report of the case, a discussion of the pathological condition represented by it, and a brief review of important literature on the subject. Manuscripts, not to exceed 5,000 words, must be typewritten in English, double or triple spaced. References must be numerically arranged at the end of the essay according to the form used by the "Quarterly Cumulative Index Medicus." Manuscripts are to be received no later than March 16, 1959, and must be accompanied by a letter from the dean of the student's medical school, stating that the author is a member of good standing of the fourth year class and specifying the expected date of graduation. They should be sent to the Editor, *New England Journal of Medicine*, 8 Fenway, Boston.

COURSES

Chest. The Council on Postgraduate Medical Education of the American College of Chest Physicians announces presentation of the Fourth Annual Postgraduate Course on Diseases of the Chest, including the most recent advances in the diagnosis and treatment of diseases of the heart and lung, medical and surgical aspects. The five day course, for which tuition is $100, including luncheon meetings, will be given at the Sir Francis Drake Hotel, San Francisco, Feb. 16-20, 1959. Further information may be obtained from the Executive Director, American College of Chest Physicians, 112 E. Chestnut St., Chicago 11.

FELLOWSHIPS AND GRANTS

Mental Health Work. Grants for in-service training of workers in mental institutions of Southern states are offered by the Southern Regional Education Board under its program in mental health training and research.

The grants are made possible by funds donated for this purpose by the National Institute of Mental Health. They are designed to enable staff members of mental hospitals or training schools in the South to observe new or unusual programs in other hospitals anywhere in the country to help them improve their own programs.

Grants are available to anyone working on the staff of a mental hospital or training school, including administrative, professional, and operational personnel. Those eligible include ward attendants, aides, nurses, rehabilitation personnel, clinical directors, superintendents, and others.

Persons interested in the grants should write to the Southern Regional Education Board, 881 Peachtree St., N.E., Atlanta 9, Ga. There is no deadline, and applications are acted upon as they are received.

Neurological Studies. The newly organized and chartered National Neurological Re-

search Foundation is offering fellowships and financial support for studies on neurological diseases, in order to promote research "into the prevention and cure of chronic, progressive disorders of the nervous system." The Scientific Advisory Committee of the Foundation will supervise the awarding of fellowships and grants as funds become available. Fellows will receive an annual stipend ranging from $10,000 to $12,000 for a period of five years. Organizations will receive grants to supplement work being carried out on neurological diseases. Information may be obtained from the National Neurological Research Foundation, 3255 N Street, N.W., Washington 7, D.C.

Pediatrics. Fellowships to pediatric residents for a period of from 6 to 12 months are offered by the American Academy of Pediatrics, to aid young physicians unable to finance completion of pediatric training. The stipends, of $500 to $1,000, will become effective July 1, 1959. Applications consist of the following: (1) a letter from the chief of service stating that the candidate has completed or will have completed by July 1, 1959, one year of accredited pediatric training; that the resident has performed her work ably; and that she is in need of financial assistance; and (2) a letter from the applicant stating that she intends to enter pediatric private practice at the conclusion of her residency training. The fellowships, made available through a grant from Mead Johnson & Company, are offered only to legal residents of the United States and Canada.

MEETINGS

Cancer Research. Genetics and Neoplastic Growth is the subject of the 13th annual symposium on fundamental cancer research, to be held Feb. 25-28, 1959, at the University of Texas M.D. Anderson Hospital and Tumor Institute, Houston. Information may be obtained from the General Chairman, Felix L. Haas, Department of Biology, M.D. Anderson Hospital, Houston 25, Texas.

Fertility and Sterility. The Third World Congress on Fertility and Sterility will be held in Amsterdam, June 7-13, 1959. Themes are as follows: embryonal death; hormonal factors and vitamins in fertility and sterility; relative value of techniques for study of endocrine functions in human sterility; biochemistry of spermatogenesis; and psychosexological problems in sterility. Full members pay a registration fee of $40; associate members, $15. Titles for papers should be submitted to Dr. Alfonso Alvarez-Bravo, Mexico City 5, D.F., Mexico, or to Prof. Dr. B. S. ten Berge, c/o Academic Hospital, Groningen, the Netherlands. For further information or application forms, write to the Secretariat of the Third World Congress on Fertility and Sterility, or to the nearest Wagons-Lits/Cook office.

Psychosomatic Medicine. The sixteenth annual meeting of the American Psychosomatic Society will be held in Atlantic City, N.J., May 2-3, 1959.

Surgery. The 24th Annual Congress of the North American Federation of the International College of Surgeons will be held at the Palmer House, Chicago, Sept. 13-17, 1959. Information may be obtained from Dr. Ross T. McIntire, Executive Secretary, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

World Medical Association. The following schedule of meetings for 1959 is announced by the Association: Thirty-Fifth Council Session, Sydney, Australia, March 25-April 4, 1959; Second World Conference on Medical Education, "Medicine—A Lifelong Study," Chicago, Aug. 30-Sept. 4, 1959; Thirteenth General Assembly, Montreal, Canada, Sept. 7-12, 1959. Additional information may be obtained from the World Medical Association, 10 Columbus Circle, New York City 19.

RESIDENCIES

U. S. Air Force. A two year residency program is offered by the Air Force at the USAF Hospital, Maxwell Air Force Base, Alabama, and certain civilian hospitals. The residencies are divided into one year training periods in medicine, including pediatrics and psychiatry, and in surgery, including fractures, obstetrics and gynecology, and traumatic surgery. Information may be obtained from the Surgeon General, USAF, Washington 25, D.C.

News of Women in Medicine

Dr. Leona Baumgartner, Commissioner of Health for New York City, was featured in a picture story on health in New York City in the September-October issue of *World Health*, published by WHO's Division of Public Information. Dr. Baumgartner, who is praised in the article for the measure of success she and her 5,000 colleagues achieve in public health, is described as "an attractive grandmother with a knowing eye for hats."

Committees reporting at the annual meeting of the Medical and Chirurgical Faculty of the State of Maryland included the following members: Drs. Caroline H. Callison, Centreville, Sarah M. Peyton, Crisfield, and Alice Tobler, Baltimore, Committee on Diabetes; Caroline A. Chandler and Janet B. Hardy of Baltimore, Maternal and Child Welfare Committee; Charlotte Silverman, Baltimore, Tuberculosis Committee; and Katherine H. Borkovich, Baltimore, Central Coordinating Committee on Polio Vaccine.

Recent promotions at the State University of New York College of Medicine at New York City include the following: from assistant professor to associate professor of medicine, Drs. Anne Cohen Carter and Harriet Bernheimer.

Dr. Elizabeth Comstock, Arcadia, Wis., was mentioned in the *Wisconsin Medical Journal* for August, in reference to a story written by her that appeared in the July, 1954, issue of the *Journal of the American Medical Women's Association*. The story concerned Dr. Margaret Caldwell, believed to be Wisconsin's first woman physician, who was born in 1845, received her M.D. degree in 1876, and died in 1938.

Dr. Evelyn Crumpton of Los Angeles was one of six physicians to carry out a three year study on the comparative effects of anesthetics and electroconvulsive therapy on schizophrenic and depressed patients. The program was sponsored jointly by the University of California School of Medicine and the Los Angeles Veterans Administration Center's Brentwood Neuropsychiatric Hospital.

Drs. Maria Domanig, St. Poelten, Austria, and Sophie Parokas, Chicago, have been certified as fellows of the American College of Anesthesiologists.

Dr. Gertrude Engbring of Chicago recently received an Alumni Citation award from Loyola University for her many years of teaching service at the Stritch Medical School.

Drs. Frances Haines, Mary M. Lyons, and Walburga Kacin were presented Awards of Merit at the 1958 Annual Meeting of the Illinois Society of Anesthesiologists for their contributions to anesthesiology.

Dr. Margaret A. Kennard, Ft. Steilacoom, Wash., has been elected second vice-president of the American Neurological Association for the coming year.

Dr. Bessie L. Lendrum of Chicago has been appointed assistant professor of pediatrics at the State University of New York College of Medicine, Upstate Medical Center. Dr. Lendrum was formerly on the faculty of the University of Illinois College of Medicine.

Dr. Kathryn S. Lovett, Statesboro, Ga., participated in a discussion program at a meeting in Athens of state mental health workers. The discussion concerned a proposed mental health program in a Georgia health district.

Dr. Helen Martin, University of Southern California School of Medicine, addressed the annual meeting of the American Geriatrics Society on the importance of routine determination of serum magnesium levels in elderly patients, to enable treatment for magnesium deficiency before appearance of clinical symptoms.

Speakers at the October meeting of the Women's Medical Society of New York State were: Dr. Annabel Miller, Chief of the

Division of Pulmonary Diseases, Veterans Administration Hospital, Buffalo, and DR. LUCY F. SQUIRE, radiologist, Strong Memorial Hospital, Rochester. Dr. Miller spoke on "The Use of Steroids in Pulmonary Diseases"; Dr. Squire discussed "Radiologic Aspects."

DR. MAY OWEN, Fort Worth, Texas, has been appointed to the Committee on Scientific Exhibits of the Texas Medical Association.

DRS. GERTRUDE L. PEASE and CYNTHIA A. STOLTZE of Rochester, Minn., presented a paper at the Midwest regional meeting of the American College of Physicians, held in September in Milwaukee. The presentation was entitled "Systematic Manifestations Associated with Keratoconjunctivitis Sicca and Sjögren's Syndrome, Including a Study of Hematologic and Protein Abnormalities." Collaborators were two other Rochester physicians.

DR. DORIS S. ROME of Albany, N.Y., presented a paper at the Seventh Annual International Cancer Congress, held in London, England, during July.

DR. MABEL ROSS of New York City has been appointed to one of the steering committees of the World Federation for Mental Health. The purpose of the committee is to co-ordinate activities among the 29 member societies in the United States.

DR. EDNA H. SABIL of the Albert Einstein College of Medicine, New York City, addressed the Queens Pediatric Society on the subject "Endocrine Factors in Growth" at the Society's meeting in October.

DR. ALICE TOBLER of the Maryland State Department of Health participated in a recent meeting of the Allegany-Garrett County Medical Society, Md. Dr. Tobler discussed costs of the County's "Medical Care" program, which provides free medical and dental services to those on county relief rolls and to those who are medically indigent.

DR. JESSIE WRIGHT of Pittsburgh participated in a special closed circuit telecast on July 22, outlining The National Foundation's new program for volunteer workers in the fields of medical scientific research, patient aid, and the training of professional disease fighters, to meet new health problems as they arise; initial emphasis will be on arthritis and birth defects.

THESE WERE THE FIRST

DR. EDITH LOEBER BALLARD (1875-1948) of Bay Saint Louis, Miss., was graduated in 1905 from Cornell University Medical College and was one of five women physicians to establish the New Orleans Hospital for Women and Children (now Sara Mayo Hospital). She is believed to have been the first woman surgeon to practice major surgery in New Orleans. Dr. Ballard was active in abolishing quack medicine from the New Orleans newspapers, and was president of the St. Joseph Clinic and Hospital in Bay Saint Louis. Her hobbies were ancient history and archeology.

DR. ELFIE RICHARDS GRAFF of Poughkeepsie, N.Y., graduated in 1905 from the Woman's Medical College of Pennsylvania, and in 1919 headed Near East relief work with the Wellesley Unit in Constantinople. She then spent two years in Russia under the auspices of the American Women's Hospitals and later went to Greece, where she worked with the AWH at Athens. Dr. Graff organized the first child welfare clinics in Constantinople and opened the first training class of native district nurses in that city.

DR. FLORENCE GRIBBLE graduated in 1907 from Hahnemann Medical College in Cincinnati and spent 24 years in the jungles of French Equatorial Africa, serving in three hospitals as the only American woman to be so employed at that time. Later, she went to India as a medical missionary of the Brethren.

DR. MERCY BISBEE JACKSON in 1871 was admitted to the American Institute of Homeopathy, Philadelphia, as the first woman physician accepted by that organization.

DR. KATE BOGLE KARPLES of Danville, Ky., graduated from Johns Hopkins University School of Medicine in 1914 and was the first woman to intern at Garfield Memorial Hospital (by competitive examination). In 1918 Dr. Karples was contract surgeon to the U.S. Medical Corps. She is past-president of the Medical Women's National Association.

—From the ELIZABETH BASS Collection,
Rudolph Matas Medical Library,
Tulane University, New Orleans.

Book Notices

Editor's Note: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

PRACTICAL GYNECOLOGY. By Walter J. Reich, M.D., F.A.C.S, F.I.C.S., Attending Gynecologist and Section Chief, Fantus Clinics of Cook County Hospital, Chicago, and Mitchell J. Nechtow, M.D., F.A.C.S., F.I.C.S., Associate Attending Gynecologist, Cook County Hospital and Fantus Gynecologic Clinic. Second Edition. Pp. 648, with 284 illustrations. Price $12.50. J. B. Lippincott Company, Philadelphia, 1957.

This practical book covers a fair number of the facts known to experienced gynecologists but too often omitted from textbooks. The advice given is reliable and the emphasis is well placed. I would like to see a better chapter on contraception, since I believe that someone should put into print the important points related to fitting a diaphragm in a woman with a congenitally retroverted uterus.

The book is outstanding for its readability and the spacing and print are excellent. It is recommended for the general practitioner and internist as a book that easily can be scanned when information is needed. It also will be very useful to the neophyte gynecologist and might serve to remind the full-fledged specialist of important facts.

—E. Catherine Cline, M.D

ELECTROCARDIOGRAPHY: FUNDAMENTALS AND CLINICAL APPLICATION. By Louis Wolff, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School, Boston, and Visiting Physician, Consultant in Cardiology, and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital. Second Edition. Pp. 342, with 199 illustrations. Price $7.00 (cloth). W. B. Saunders Company, Philadelphia, 1956.

This book is avowedly directed to the medical student and general practitioner. One must not look, therefore, for the newer esoteric concepts in electrophysiology.

The first section contains a complete discussion of the accepted classical theories of the basic principles. The diagrams are simple and the text is clearly written. Electrical phenomena, the cell membrane, volume conductors, the various leads, concepts of deviation of the electrical axis, muscle injury, and conduction defects are all discussed. The anatomy and physiology of the heart and the application of these theories to the action and structure of the heart are also included. This is the best section in the book.

Part II is on clinical electrocardiography. There are representative illustrations of the usual electrocardiographic abnormalities encountered in clinical medicine. The reproduction of the electrocardiograms is not of the highest quality. The section on localization of infarcts is rather arbitrary and probably misleading. There is not sufficient emphasis on the point that such localization is often incorrect and even impossible. In the discussion of anomalous atrioventricular excitation included in this section, the terms "excitation" and "conduction" seem to be used interchangeably, which is inaccurate.

The final section is on the cardiac arrhythmias and is probably the poorest section in the book. The illustrations are not the most applicable and many of them are very poor. The chapter on atrial flutter contains the most unfortunate records, and, indeed, it is possible that at least one of the cases does not represent atrial flutter at all. The section on complete atrioventricular block is especially incomplete and does not mention the important point of slowing idioventricular centers and the onset of ventricular premature systoles and their relation to the serious complication of ventricular fibrillation and syncope. The danger of using quinidine or procainamide in this syndrome is now so generally accepted that it seems negligent to have omitted this point.

Lastly there is no bibliography in this textbook. For a textbook in the medical field not to cite references seems to be courting early oblivion.

—Bertha Rader, M.D.

OCCIPITOPOSTERIOR POSITIONS. Publication No. 310 of the American Lecture Series. By Edward L. King, M.D., F.A.C.S., F.A.C.O.G., Professor Emeritus of Obstetrics, School of Medicine, Tulane University, New Orleans. Pp. 114, with 60 illustrations and 2 tables. Price $3.75 (cloth). Charles C Thomas, Springfield, Ill., 1957.

This excellent treatise reviews the whole subject of occipitoposterior positions. It discusses etiological and diagnostic features and general management of labor with this condition present. Emphasis is on the forms of treatment, nonoperative and surgical. These are illustrated with diagrams and photographs and documented with references to the original work. Nonoperative procedures are notably those advocated by Pomeroy and Danforth.

The evolution in the operative delivery of fetuses presenting an occipitoposterior position over the past 200 years is presented briefly but with sufficient data and illustration to give a clear, "working" picture. Included are the instruments and techniques of

Smellie (1751), Scanzoni (1855), Kjelland (1916), Barton (1925), and DeLee (1947). The forceps, methods of application, rotation, and traction are shown in each case.

The value of this book is that it makes readily available knowledge of the historical background and present-day techniques for dealing with this ever-present obstetric problem.

—*Georgia Reid, M.D.*

HISTAMINE: A Ciba Foundation Symposium. Conducted jointly with the Physiological Society and the British Pharmacological Society. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 472, with 133 illustrations. Price $9.00 (cloth). Little, Brown & Company, Boston, 1956.

The contents of the societies' symposium is divided into three parts: Occurrence of histamine in the body, release of histamine, and the origin and significance of histamine. The Ciba Symposium is divided into two sections. Part 1 is concerned with the origin and fate of histamine in the body and part 2 with the location of histamine in the body and the mechanism of histamine release.

The following points may be emphasized: Histamine is widely distributed in the body and there is scarcely any organ without it. It is particularly concentrated in the mast cells and also occurs in tumors. The release of histamine is achieved by various physiological means and sundry agents among which are the toxins, antigens, proteolytic enzymes, surface active substances, gastrin, and even histamine antagonists. The relation of endogenous histamine to gastric secretion is fully discussed. Its role in various vasodilator phenomena and in neurohumoral transmission; the inhibiting effect, or histaminase, of thiamine, sulbamidine, synthetic estrogens, and steroids; and the potentiation of histaminase by natural estrogens and pregnancy are amply covered. In short, this extensive symposium crystallizes much of the current information on histamine and is an excellent source for the student interested in this subject.

—*Anita H. Sternberg, M.D.*

THE STORY BEHIND THE WORD. By Harry Wain, A.A., B.S.M., M.D. (cum laude), M.S.P.H., Diplomate, American Board of Preventive Medicine; Fellow, American College of Preventive Medicine and American Public Health Association; Member, Royal Society of Health, London, England, and American Medical Association; and Health Commissioner, Mansfield-Richland County, Ohio. Pp. 342. Price $8.50. Charles C Thomas, Springfield, Ill., 1958.

The title leads one to anticipate an hour of interesting reading but the contents do not live up to expectation. This book is a miscellaneous collection of words, not all closely connected with medicine, and most of the derivations are found in more concise form in the standard medical dictionaries.

A few entries supply facts not usually known, although it may be hard to verify their source. The Egyptian ibis really started something if its behavior gave rise to the procedure of "enema." "Sacrum" is given added importance on the resurrection day by one of the suggested origins of the word. "Thymus" has a touch of antiquity back to Galen along with other allusions not found in the briefer dictionaries. Changes in the meaning of "toilet" followed its transition from weaving and web via wild beasts and clothes to dressing tables and water closets. "Whisky" considered as a water of life will give comfort to its advocates.

This is a good book for students of linguistics but will not supplant a modern dictionary.

—*Josephine G. Nichols, Ph.B.*
Librarian, New York Infirmary

CLUES TO SUICIDE. By Edwin S. Schneidman, Ph.D., and Norman L. Farberow, Ph.D., Veterans Administration Neuropsychiatric Hospital and Veterans Administration Mental Hygiene Clinic, Los Angeles; with a foreword by Karl A. Menninger, M.D. Pp. 227. Price $5.50 (cloth). Blakiston Division, McGraw-Hill Book Company, Inc., New York, 1957.

This volume, comprised of contributions by 19 authors, contains a collection of 18 sections, a postscript, and an appendix. This makes for uneven reading and some redundancy. The material compiles important observations on the prevalence of suicide, theories of causation, and methods of handling potentially and presumably suicidal patients. Comments on symptoms, motivation, and results of treatment while necessarily sketchy are thought-provoking and should alert both student and resident staff to the clinical hazards as well as stimulate further observation and research. The well-documented material and excellent bibliography make it easy to refer to original sources for greater detail.

Part 11, Clinical Considerations, should be required reading for all those entering the field of clinical medical practice, especially section 15 on Suicide in a General Hospital by Dr. Pollack.

This work is especially recommended for the shelves of the hospital medical library. It is a well-made book of convenient size with a good index and easily read type.

—*Helen P. Langher, M.D.*

THE VISUAL FIELDS. A Textbook and Atlas of Clinical Perimetry. By David O. Harrington, M.D., F.A.C.S., Clinical Professor of Ophthalmology, University of California School of Medicine, and Consultant in Ophthalmology, U.S. Veterans Administration Hospital, Fort Miley, San Francisco. Pp. 327, with 234 illustrations and 9 color plates. Price $16.00. The C. V. Mosby Company, St. Louis, 1956.

This textbook on perimetry is of particular interest to the ophthalmologist and neurologist. It presents many new ocular measuring techniques developed during the past few years and correlates visual field interpretations with the associated anatomic lesions producing them. Copious excellent illustrations amplify this well-organized text.

—*Robert E. Murto, M.D.*

ATTENTION AMWA MEMBERS
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SOFTENS ACTIVATES

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In constipation, Metamucil produces SOFT, easy stools and activates gentle peristalsis. By adsorbing and retaining water within the stool Metamucil prevents hard feces from forming. And it adds to the intestinal residue a soft, plastic bulk which ACTIVATES the normal reflex activity of peristalsis.

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SEARLE

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

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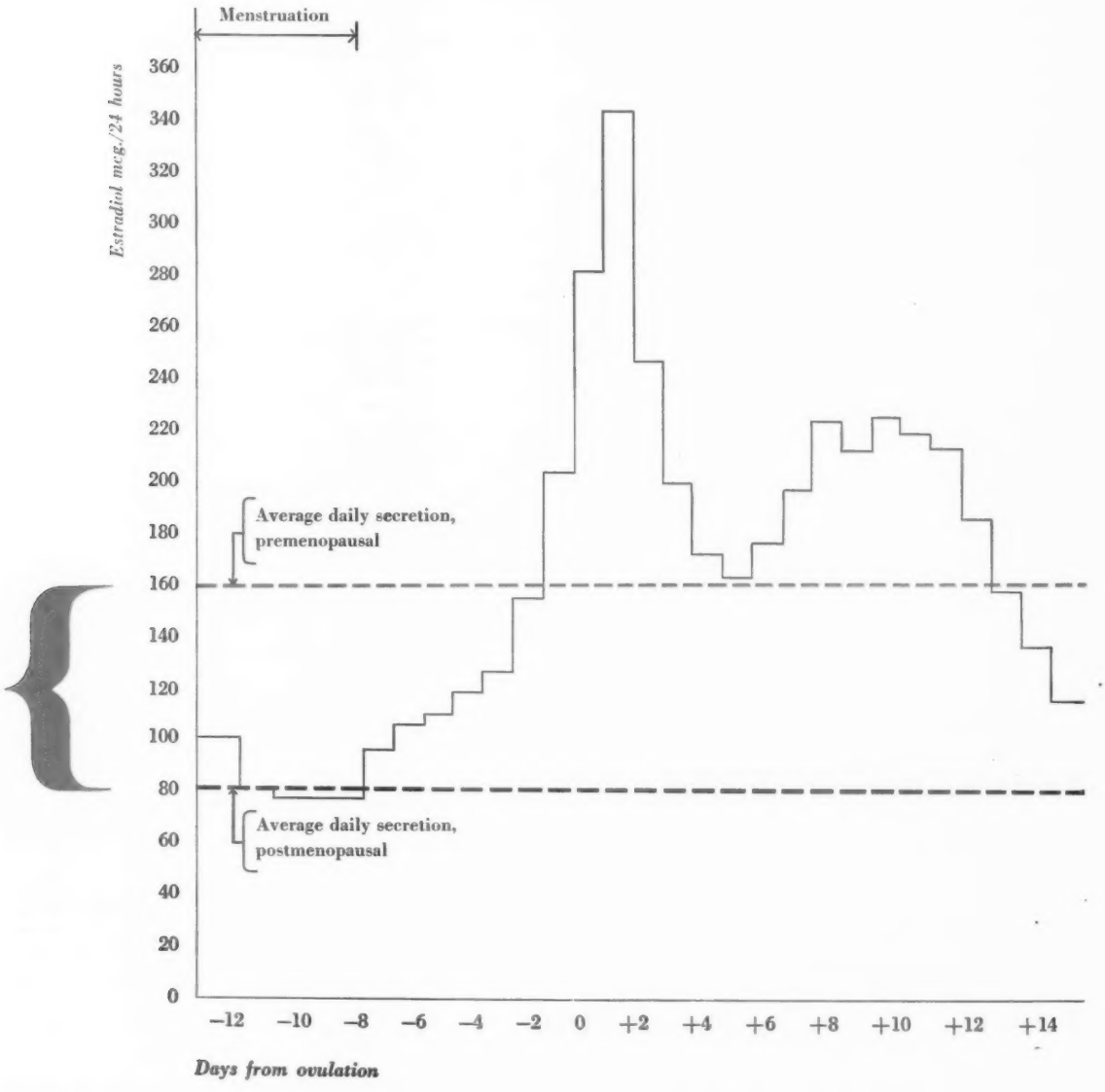
Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)



This is an advertisement.

Sebaceous activity as related to health and care of normal and aging skin

Dermatologic Research for Improved Cosmetology

Today, scientific principles are essential in formulating cosmetic products. Many new synthetic compounds and procedures have been developed. But controlled research has not kept pace with these advances. "The need for increasing the scope and number of investigations relating to fundamental problems of skin physiology, biochemistry, pharmacology, and toxicology cannot be stressed too strongly."[1]

Much remains to be learned of the relationship between sebaceous gland activity and the cosmetic care of the skin. Confusion exists among physicians, pharmacologists and cosmetic chemists concerning the use and properties of a skin emollient[2]—which may be defined as "...externally applied material that tends to prevent or counteract the symptoms and signs of dryness of the skin."[2] The emollient preparations of the cosmetologist and the topical prescriptions of the physician have much in common.[2]

The Sebaceous Glands... Key Factors

Sebum, the excretory product of the sebaceous glands, forms a film which diffuses all over the skin's surface and penetrates between the horny lamellae of the stratum disjunctum.[3] This film protects against abrupt temperature and humidity changes,[3] and helps to maintain the normal resiliency and hydration of the horny layer.[4]

Distribution of the Sebaceous Glands

Sebaceous glands cover the body surface with the exception of the palm and the sole and dorsum of the foot.[5] They are found in greatest abundance—approximately 400 to 900 per sq. cm.—on the scalp, forehead, face and chin; over the rest of the body—in quantities that average less than 100 per sq. cm.[5]

Structure and Cellular Morphology

The sebaceous glands are acinar, holocrine glands.[6] Mitosis originates from the outermost germinative cells of the gland and proceeds through successive layers in a continuous stream of oil-forming cells toward the center. During this movement, cells grow larger with an accumulation of fat droplets. Finally, fat distension within cells becomes so great that cell walls disintegrate with the liberation of lipid.[4]

Histochemical studies[7,8] show phospholipids in the matrix cells of the acini and their gradual disappearance with increased lipid infiltration. This transformation has been linked with mitochrondrial filaments and Golgi elements.[8,9] Immature cells contain glycogen.[10] Succinic dehydrogenase,[11] alkaline phosphatase,[12] and nonspecific esterases[13] have been noted.

Mechanism of Sebum Excretion and Distribution

Three factors chiefly regulate sebum flow to the skin surface—(1) number of glands in a unit area; (2) skin temperature, and (3) emulsifying action of sweat.[4] Starting with a defatted surface, excretion sets in rapidly. When the surface layer reaches a thickness sufficient to counteract the glandular force, fat expulsion stops.[14,15] With subsequent defattings, excretion is resumed.[14,15] A recent report[16] disputes this "feedback" concept claiming that "...the sebaceous gland functions continuously, without regard to what is on the surface."[16] High temperatures keep the film liquid; at low temperatures, sebum solidifies and counteracts glandular excretion at lower levels.[17] Sweat secretion emulsifies sebum and facilitates its spread.[18] The tremendous effect of sweating on spreading of the film has been shown.[18] Regional differences in sebum secretion are paralleled by corresponding changes in sweat delivery.[19]

Chemical Composition of the Skin Surface Film

The surface film is a complex mixture of fatty acids and their cholesterol esters, wax alcohols, glycerol, free cholesterol and hydrocarbons—notably squalene.[20] Free fatty acids apparently contribute to the antipathogenic[21] and "self-sterilizing"[22] character of the film. The wax alcohols and cholesterol act as emulsifiers. Squalene is typical of human fat while its chemical counterpart, lanosterol, is peculiar to the sheep. Horse sebum bears the closest known relationship to human sebum[9] despite commercial claims made for lanolin in this respect.

Influence of Sex Hormones on Sebaceous Activity

Sebum secretion rises sharply with puberty.[23] It then levels off, becoming constant at about 25.[24] In old age there is a decrease of sebaceous activity in women.[25,26] Sex hormone factors are critical for the stimulation and development of sebaceous gland activity. "Progesterone definitely stimulates sebaceous gland growth,"[26] by increasing the number of sebaceous cells.[4] A pituitary factor, sebotropin, appears to be essential for the maintenance of the sebaceous glands and for their striking response to stimulation by the sex hormones.[27]

Topical Management of the Skin as Related to its Sebaceous Activity

The new scientific soaps and detergents have proved useful for needed day-to-day removal of excess oil as seen in seborrheic and greasy skins. Dryness responds to suitable emollients which act on the skin surface to help guard against undue moisture loss. "An effective emollient must be so constituted that it will help the stratum corneum maintain an adequate water content."[2]

In aging skin the problem is to help the skin by stimulating lost sebaceous function. Progesterone applied topically increases the surface emolliency of dry, aging female skins as shown by *in vivo* staining of unsaturated fats at inunction sites and in tissue sections.[28]

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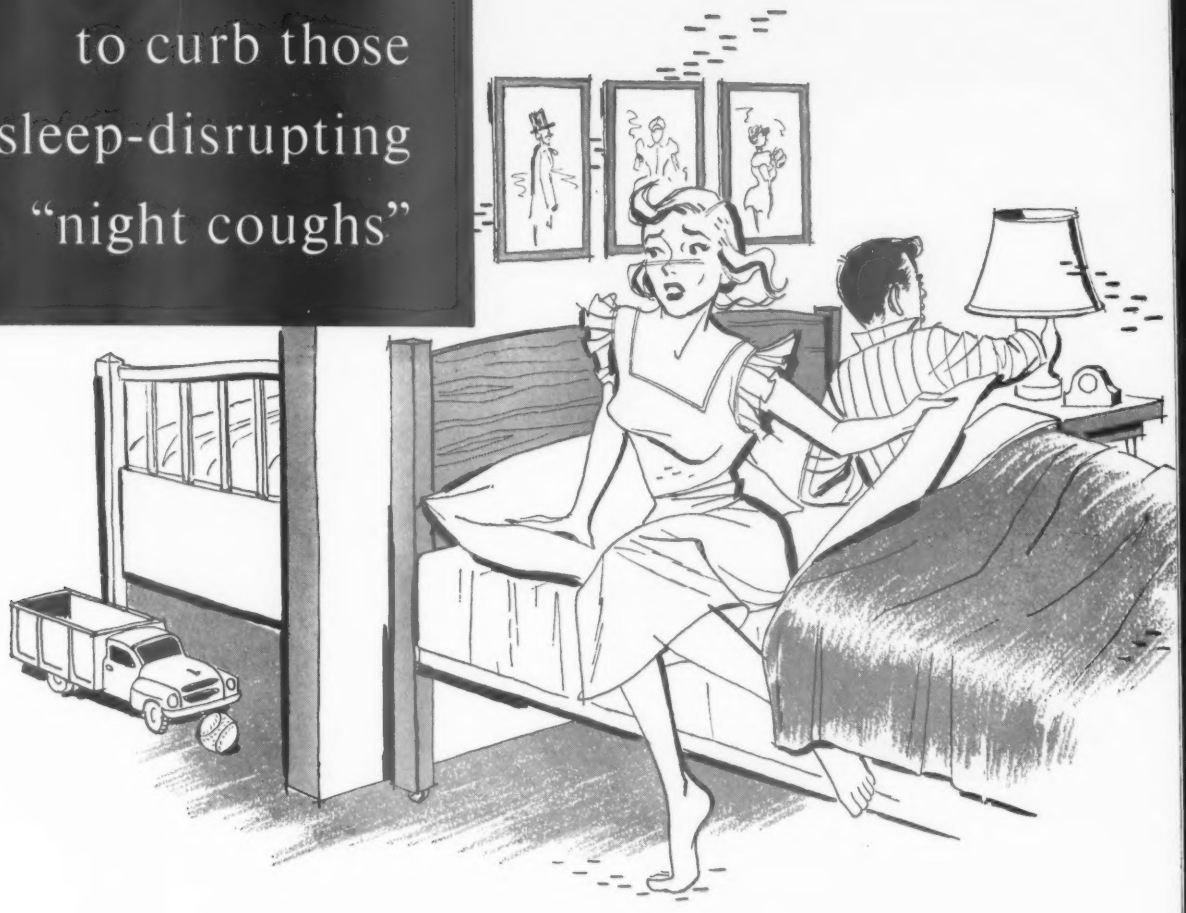

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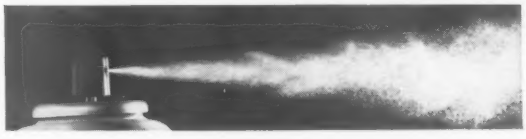
need  ...

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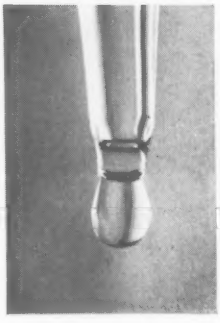
widely used  and

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